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# Citizenship and Immigration Canada, Ontario Region Improving Health Outcomes for Government Assisted Refugees –Final Report

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Produced by:



PSTG Consulting

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## Introduction

Since 2002, with the introduction of the Immigration and Refugee Protection Act (IRPA), Canada has increasingly accepted refugees based on the need for protection and less on the ability of the refugee to become established in Canada. In support of this policy decision, the IRPA introduced a number of changes in the selection process for refugees, including waiving health status or disease condition as a selection criterion. Consequently, refugees are now accepted regardless of their health status.

In the past five years, approximately 7,500 Government-Assisted Refugees (GARs) have arrived in Canada annually. Of these approximately 2,300 are destined for Ontario annually. To assist GARs with their integration into Canadian society, Citizenship and Immigration Canada (CIC) provides financial support and immediate essential services through the Resettlement Assistance Program (RAP). In Ontario, six cities have been designated as GARs receiving sites, and organizations in Hamilton, Kitchener, London, Ottawa, Toronto and Windsor are funded by CIC to deliver RAP. In addition to RAP, CIC, Ontario Region funds the Client Support Services Program (CSS) in all of the six RAP Service Provider Organisations (SPOs). This program provides access to a comprehensive and intensive range of support services for all GARs arriving in Ontario for their first year following their arrival.

Government Assisted Refugees face unique health and settlement challenges related to their pre-migration experiences and/or protracted stays in camps, including exposure to illness and disease, atrocities, extreme loss, violence, and a lack of access to shelter, nutrition and basic services. Consequently, the physical and mental health of this vulnerable group is a critical settlement issue for CIC. In March 2011, CIC completed a national evaluation of the RAP Program and GAR Program which suggests that the medical needs of refugees has increased since IRPA. Further, CIC's evaluation of the Client Support Services Pilot Program in 2009 identified health and mental health as unmet needs.

At the same time, the health service needs of GARs are not well understood and thereby there is no policy to guide SPOs to address the health care issues presented by GARs arriving in Ontario. As a result, settlement and health service providers in the six refugee receiving cities in Ontario have developed individual health services and programs to respond to the unique health needs presented by GARs. Although anecdotal evidence suggests that there lacks a consistent approach to service delivery, there is a lack of documentation describing or assessing the models to support this claim.

In April 2011, CIC, Ontario Region contracted with PSTG Consulting to carry out a study to document the current service delivery models and to make recommendations for a more standardized approach to health service delivery across the six GARs receiving sites in Ontario.

## Study Objectives

The study was undertaken in order to:

- Better understand and assess the current health service response to GARs in the six GARs receiving cities;
- Leverage best/promising practices currently being undertaken by health/mental health and settlement service providers for GARs in Ontario;
- Develop recommendations to enhance health service delivery to GARs across the province so that services are more effective, efficient, comparable, and measureable; and
- Develop models, tools, frameworks, and guidelines for service provider organizations across Ontario that will be used to move towards a more standard response across the province.

## Methodology

The approach to this study to date has consisted of the following key activities:

- Review of documents (e.g. CIC, Ontario Region Client Support Services for Government Assisted Refugees Evaluation of Province-wide Pilot Initiative – Final Report 2009, Health Management Protocol for Karen Refugees 2007, etc.);
- Telephone interviews with staff from the RAP and CSS at the six GAR receiving cities in Ontario – Hamilton, Kitchener, London, Ottawa, Toronto, and Windsor, and the CSS Regional Coordinator
- Telephone interviews with health service providers working with the CIC contracted SPOs to deliver health services to GARs at the six sites;
- Consolidation of interview information and preliminary analysis and reporting of the service delivery processes, challenges, and promising practices in health service delivery to GARs;
- Site visits to the reception centres and health service provider organizations with which the SPOs partner at the six GAR receiving cities;
- Roundtable discussions with settlement SPOs and health service partners to review findings from the telephone interviews and to validate:
  - Challenges to service provision;
  - Best practices for the delivery of health services to GARs in their first year in Ontario; and
  - Process maps describing the health service delivery model of each site;
- Consultations with CIC staff at the Interim Federal Health Program (IFH), the Refugee Branch, and the Settlement Branch;
- Collection of existing tools, frameworks, and guidelines for health service delivery from the six sites; and
- Consolidation, analysis, and the preparation of this Interim Report presenting study findings and options for improvement.

The activities of this study that will follow this report are:

- A two-day workshop with health and settlement SPOs of the six sites to review and assess the options, and to identify priorities for implementation that will lead to more effective, efficient, comparable, and measureable health service delivery to GARS across the province; and
- The consolidation of feedback from the workshop and the generation of a Final Report.

Please see Appendix A for interview and roundtable discussion participants. Please see Appendix B for the interview and roundtable discussion guide.

The original methodology included the administration of a survey to settlement and health SPOs of the six sites. After a series of initial telephone interviews were conducted with RAP and CSS staff at each of the sites and the health service provider partners that they identified (as part of the process for developing the survey) it was determined that a survey could not capture the information required. As a result the survey was eliminated, and in its stead another round of in-depth interviews was undertaken with health and settlement SPOs.

Throughout the study there was frequent interaction with the CIC, Ontario Region Project Lead. This allowed the PSTG project team to present and validate findings and test ideas throughout the project.

## Limitations

There is limited documentation available regarding optimal health service delivery to GARS. As a result, the practices identified in this report, are described as “promising” as opposed to best. While service provider experience has identified these practices as good practices with positive outcomes, in most cases there is not evidence to validate this.

## Note

This study is focussed on service delivery models and processes. It does not address, review, assess, or make recommendations regarding clinical health services or outcomes.



## Background and Rationale for the Project

This study has been undertaken in response to the lack of a coordinated and standard approach to address the health needs of government assisted refugees in their first year in Ontario.

### Health of GARs in Ontario

In 2008, 7,295 government assisted refugees arrived in Canada, and 2,450 of these were destined for Ontario. Table 1 below illustrates the rate of arrivals to Ontario during the 2008 – 2010 period.

Table 1: GAR Arrivals in Ontario (2008-2011)

	London	Ottawa	Toronto	Kitchener	Windsor	Hamilton	Total
<b>2008</b>	225	332	890	273	267	322	2309
<b>2009</b>	262	354	851	249	288	368	2372
<b>2010</b>	244	484	1082	285	299	403	2797

In 2002, Canada waived the burden-of-illness barrier for refugees who fled their countries of origin because of well-grounded fears of persecution. As a result, unlike most other immigrants, many refugees come directly from refugee camps in the developing world. Moreover, during what are increasingly protracted stays at camps refugees are exposed to illness and disease, atrocities, extreme loss, violence, and a lack of access to shelter, nutrition, and basic services. Consequently, refugees arriving in Canada experience multiple challenges which negatively affect virtually all social determinants of health reducing their overall wellbeing and ability to integrate effectively into Canadian life. Consequently, GARs are widely recognized as among the most marginalized members of society with poorer health, greater health needs, and more significant access barriers than immigrants and Canadian-born citizens, and therefore they are at increased risk of infectious and other preventable diseases. Health issues that are of particular importance to displaced populations include not only obvious problems such as trauma, malnutrition/dehydration, and communicable diseases, but also more subtle and long-term issues such as post-traumatic stress disorder (PTSD) or exacerbation of chronic conditions.

Recent evidence from a large national Canadian study showed disparities in mortality patterns between immigrants—particularly refugees—and Canadian-born people.<sup>i</sup> In the United States, studies have shown that refugees have elevated rates of a number of infectious diseases, including preventable and treatable illnesses such as tuberculosis (TB), chronic hepatitis B, and intestinal parasites.<sup>ii</sup> Despite their health needs, refugees typically do not seek medical or health services until they are seriously ill, leading to an overuse of costly emergency and acute-care services. Health service providers suggest that refugees need assistance to understand how the health system can help them to live healthy lives in their adopted country<sup>iii</sup>. Several authors have suggested the need for domestic refugee health assessment programs with a focus on infectious diseases<sup>iv</sup>. In Canada, Beiser<sup>vi</sup> has suggested that current policies on the health of refugees upon arrival and on their integration into the Canadian health care system remain inadequate.

### **GARs Studies in Ontario**

Results from a recent study undertaken with GARs in Ottawa demonstrated that refugees had significantly higher rates of treatable and preventable infectious and chronic diseases compared with Canadian-born people. For example, the latent TB rate was 49.5% and the rate of intestinal parasites was 13.6%. The study concluded that systematic screening, early identification of health problems, and targeted health promotion are key to maintaining and enhancing the health of GARs. In addition, the study calls for a comprehensive health settlement program for GARs.<sup>vii</sup>

A study of GARs in Toronto carried out by a group of providers working with Karen refugees found that the health<sup>viii</sup> needs of this population were effectively identified through the implementation of an initial assessment process and an effective screening protocol. This enabled the identification of both infectious and non-infectious issues and allowed medical practitioners to undertake early interventions. The study team concluded that all GARs should have access to an initial health assessment and called for the development of and/or improvement to, evidence-based guidelines to illustrate the usefulness of such screening. The study suggests that the absence of a national strategy for health screening and care of new Canadians such as the Karen refugees stems in part from the paucity of medical literature available to guide such efforts. By delineating the burden and patterns of disease in this population, the study authors hope to contribute the evidence necessary for the development of an effective screening protocol for newly arrived refugees<sup>ix</sup>.

## CIC Response to GARs

The Resettlement Assistance Program (RAP) is a federal program that consists of two components. The first is a financial assistance program designed to support GARs for one year after their arrival in Canada. This involves providing income for the basic needs of life and immediate essential services for a period of 12 months, and in the case of GARs with special needs, for 24 months. The dollar amount provided mirrors social assistance rates and is allocated for the cost of rent, food, transportation, as well as other basic costs such as start-up money for household goods, furniture, and clothes for newborn babies. The second component is to provide orientation services to help GARs meet their basic and immediate needs, and to assist GARs during their first four to six weeks of arrival in Canada. RAP orientation services include:

- Meeting GARs when they arrive in the country and providing transportation to temporary accommodation (i.e. reception centres);
- Providing temporary accommodation at one of the six reception centres located in Hamilton, Kitchener, London, Ottawa, Toronto, and Windsor;
- Assisting in finding permanent accommodation;
- Providing start-up furniture and helping to set up a telephone line;
- Orientation to finance and budgeting;
- Orientation to the education, health care, and housing systems and services;
- An introduction to their new community, community mapping, and transportation services;
- An overview of language training and if applicable assistance in making an appointment for language assessment; and
- Links to government programs and community services.

GARs are covered by IFH from the first day of their arrival in Canada and the Ontario Health Insurance Program (OHIP) from the day their application is approved, usually one to 30 days from their arrival. Typically IFH coverage, like RAP, is provided for the first year of the GARs time in Canada. High needs clients who have limited or no literacy in their own first languages or who have little or no experience living in an urban environment are generally recommended to participate in a Life Skills program which provides essential help with basic life and functional skills for the first few weeks after arrival, such as assistance with grocery shopping and laundry. Following completion of the Life Skills program, most GARs are referred to the CSS program for more in-depth, client-centred service support for an extended period of time. As the Life Skills program is provided to GARs with high needs, those clients who do not participate in Life Skills may be referred to the CSS program in their first few weeks in Ontario.

While the RAP and Life Skills programs are designed to meet initial short-term needs, they do not address the obstacles that GARs encounter in their first years of the resettlement process. CSS has three key program components: case management; community capacity building; and a coordinated approach. One of the main indicators of the need for CSS was the lack of resources dedicated to identifying and serving GARs' extensive health needs, including mental health needs. With CSS operating well into its fourth year (as the pilot began in January 2007), year-end statistical reports reveal that health is the top average client need as seen in Figure 1<sup>x</sup>.

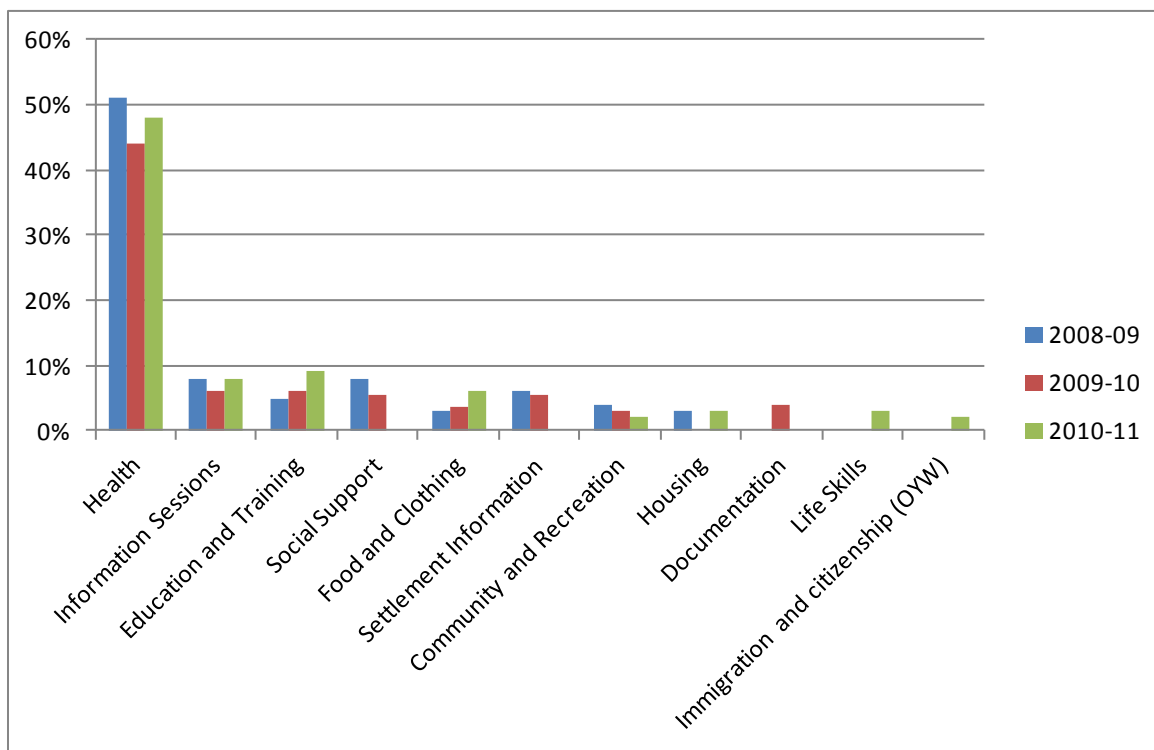


Figure 1: GARs Needs in Their First Year in Ontario Across the Six Sites (2010-11 does not include Hamilton)

However, because the CSS program is client centered and designed to respond to the unique needs of its population, each of the six sites has developed its own project model, including health service delivery, based on the unique needs of its specific communities and GARs<sup>xi</sup>.

## Health Policy, Programs, and Protocols

Beyond the IFH program, federal policy and programs regarding the management of GARs health have been limited to exceptional circumstances. Since 2004, CIC has issued two health protocols to address the health issues of the Karen and subsequently the Bhutanese populations.<sup>xii</sup> Many health service providers have suggested that these protocols should be expanded to cover all GARs. Policies and/or programs have not been developed by the Ontario Ministry of Health and Long-Term Care (MOHLTC), which has responsibility for health in Ontario, to address GARs health issues.

As cited in the Introduction, many health service providers that work with GARs have identified not only gaps in federal and/or provincial policy, but also a lack of clinical evidence to support practice regarding GARs health. In response, the Canadian Collaboration for Immigrant and Refugee Health (CCIRH), recently published comprehensive evidence-based guidelines that will help health service providers meet the health needs of immigrants and refugees.

## Current State

### Introduction

This section presents the current state of health service delivery to GARs in their first year in Ontario. First, the general context for the current state in Ontario will be described. Subsequently, a profile of each of the six GARs receiving cities is provided that includes:

- The specific context for each of the six sites;
- A narrative description and process map of the health service delivery process;
- The partner organization(s) and/or provider(s) involved and their roles and relationships;
- Challenges to health service delivery; and
- Promising practices.

The current state presented refers to the state as of August 2011.

### Background

As is the case across Canada, RAP in Ontario is well established and has been in operation since 1998. In 2005, CIC, Ontario Region funded a Case Management Pilot (CMP) project in Toronto to provide and test a case management approach to settlement service delivery to 70 GAR families/cases during their first year in Canada. The profile of refugees selected for Canada's RAP Program has changed with the passage of the Immigrant Refugee Protection Act (IRPA) in 2002 which now places an emphasis on protection of refugees as opposed to their ability to resettle in Canada. The result has been GARs arriving to Canada have more complex needs and require more assistance. In 2007-2008, the CMP pilot was rolled out across the province to the six RAP SPOs as the CSS pilot/program; enhancing and collaborating with immediate services provide by RAP and Life Skills. In addition, the CSS regional coordination has developed a central database management system that collects and consolidates program activities, outputs, and outcomes.

Table 2: GARs Needs in Their First Year in Ontario Across the Six Sites (2010-11 does not include Hamilton)

Needs Category	2008-09	2009-10	2010-11	Average
Health	51%	44%	48%	48%
Information Sessions	8%	6%	8%	7%
Education and Training	5%	6%	9%	7%
Social Support	8%	6%	0%	5%
Food and Clothing	3%	4%	6%	4%
Settlement Information	6%	6%	0%	4%
Community and Recreation	4%	3%	2%	3%
Housing	3%	0%	3%	2%
Documentation	0%	4%	0%	1%
Life Skills	0%	0%	3%	1%
Immigration and citizenship (OYW)	0%	0%	2%	1%

At this time, there is no formal mandate of or from CIC to the six sites to deliver health services to GARs. Although there is no formal accountability, either through reporting requirements or contribution agreements, in place for the provision of health services to GARs in Ontario, health needs among GARs are significant and are being addressed through current CIC funded delivery systems. Data collected through the CSS program has demonstrated that health needs are significant in GARs; at least one health need was identified per client from April 2008 through March 2011<sup>xiii</sup>. (Note: this information may not represent the total number of GARs destined to Ontario as CSS only provides services to high needs clients and thereby may not assess or case manage all clients. However, this information is best proxy for the needs of GARs in Ontario at this time.) Across the five sites, on average from 2008 through 2011, GARs health needs were rated as 48% of the total client needs as seen in Table 2. Further, health remained the highest ranked need throughout the GARs first year in Ontario. Indeed, as seen in Figure 1 and Table 2, the rank of health needs was above 40% throughout the entire first year whereas the next highest need was at most under 10%. Table 3 shows that every GAR in Ontario reported between one and five health needs to the CSS program during their first year in Canada in 2010/2011. It is of note that the information for Hamilton and Toronto are lower due to the fact that referrals for health were assessed, tracked, and monitored by external support services separate from the CSS program, i.e. a Nurse Practitioner in Hamilton and Access Alliance Multicultural Health and Community Services in Toronto. Table 3: Health Needs Reported Per GAR in Their First Year in Ontario

Site	2008-09	2009-10	2010-11	Average
Hamilton	1	0.9	-	1
Kitchener	5	5	5	5
London	2	3	3	3
Ottawa	6	4	2	4
Toronto	1	1	1	1
Windsor	3	5	3	4

The data collected by the CSS program calls for an overarching CIC response to the health service needs that are being identified by GARs across Ontario. At this time, all six of the GARs receiving sites in Ontario have independently developed service delivery processes and relationships, both formal and informal, to deliver health services to their clients. These include:

- Services to respond to emergency, urgent, primary, and secondary care needs during the time that GARs are living at the reception centre; and
- Services to respond to emergency, urgent, primary, and secondary care needs throughout the GARs first year in Ontario, and at two of the GARs sites into the second year, whether they are at the reception centre or living in their permanent accommodations.

Through interviews and roundtable discussions, both RAP and CSS staff reported that, while it is valuable to provide health services dedicated to GARs during the time that they live at the reception centre, these services should be extended minimally for the first year in Ontario. They argue that emergency and urgent health needs are routinely identified immediately by the GARs, however, other health needs are often identified by the GARs to their CSS staff only after they have been in Ontario for several months and after they have left the reception centre. CSS staff explain that after about three months, many of the GARs immediate needs (e.g. securing housing and furniture, enrolling in school/education, establishing financial accounts and credit) have been met. It is at this time that health complaints, which may have been previously ignored as being lower in priority, are identified. This is supported by CSS data that shows that health needs are consistently the highest need of GARs, see Table 4.

Table 4: GARs Needs in Their First Year in Ontario across All Six Sites (2010-11 does not include Hamilton)

	2008-09			2009-10			2010-11		
Needs Category	0-3 mth	4-6 mth	7-12 mth	0-3 mth	4-6 mth	7-12 mth	0-3 mth	4-6 mth	7-12 mth
Health	3%	39%	25%	45%	55%	45%	60%	58%	52%
Information Sessions	17%	9%	14%	12%	7%	12%	8%	6%	9%
Food and Clothing	54%	4%	0%	3%	0%	0%	4%	9%	2%
Education and Training	8%	6%	3%	6%	4%	4%	10%	6%	7%
Life Skills	0%	0%	0%	0%	3%	4%	6%	9%	9%
Community and Recreation	0%	5%	5%	0%	3%	4%	3%	3%	2%
Housing	0%	4%	5%	0%	0%	3%	5%	4%	4%
Financial (Assistance)	0%	6%	6%	0%	4%	8%	0%	0%	0%
Documentation	3%	0%	6%	4%	5%	4%	0%	0%	0%
Consumer Information	3%	4%	7%	0%	0%	0%	0%	0%	0%
Family Issues	0%	0%	12%	0%	0%	0%	0%	0%	0%
Social Support	6%	0%	0%	5%	0%	0%	0%	0%	0%
Settlement Information	4%	0%	0%	5%	0%	0%	0%	0%	0%
Social Services	0%	0%	0%	3%	3%	0%	0%	0%	0%
Employment	0%	3%	0%	0%	0%	0%	0%	0%	2%
Immigration and citizenship (OYW)	0%	3%	0%	0%	0%	0%	0%	1%	0%
Learning English	0%	0%	0%	0%	0%	0%	2%	0%	0%



The service delivery processes that meet the emergent and primary care needs while GARs are in residence at the reception centre have been more thoroughly established at all six sites than the service delivery process to GARs upon their transition to permanent accommodations. Recognizing the importance of health services to GARs, the sites have formed formal and/or informal relationships with primary care providers located within a short distance of the reception centres.

Each of the six sites is assisting GARs to access to health services although that responsibility is not outlined in the activities, targets, or outcomes of their agreements with CIC and there are no program guidelines to define the nature of this function. Consequently, there is no specific funding from CIC for health services, and sites are independently and with various degrees of success pursuing diverse sources of funding to deliver health services. As a result, across the province funding for GARs health services is inconsistent. The Interim Federal Health Program (IFH) is funded by the CIC and gives temporary health care coverage to GARs (among other groups) to help them to receive needed care, integrate into society and reduce risks to public health.<sup>xiv</sup> Although many of the health services that are sought by GARs are covered by IFH, those services can only be provided by health service providers that know about and are registered with IFH, and for those services included in its coverage.

In addition, GARs are eligible for OHIP as soon as they arrive in Ontario. Once GARs are approved for OHIP and receives their OHIP cards, health services where possible, are billed through OHIP, and not to IFH. There are, however, discrepancies across Ontario regarding how long GARs must wait to receive their OHIP cards upon arrival at the reception centre. This is due to the reception centre being a temporary address for GARs and some OHIP offices will not accept the reception centre's address on the GARs applications for OHIP coverage whereas others will. The delay in receiving OHIP coverage can delay the provision of both health services and health equipment such as wheelchairs (details will be discussed in the site descriptions).

Finally, there are two sites that have acquired other means of funding health service provision to GARs. One site secured funding from the Local Health Integration Network (LHIN) for a Wellness Centre and the second secured funding from the MOHLTC Nurse Practitioner Secretariat for an onsite Nurse Practitioner and clinic (details will be discussed in the site descriptions).

## Hamilton

### Context

Hamilton is unique as a site in that the contract for RAP and CSS services had only been awarded to Wesley Urban Ministries in May of 2011. The site began receiving GARs June 6, 2011. RAP was operational as of the time this study was underway, whereas CSS services came online in August, 2011. Prior to May 2011, RAP and CSS services had been delivered by a different service provider organization which ceased operations at the end of 2010. The transition from the previously contracted service provider to Wesley Urban Ministries resulted in a period from January through June 2011 in few GARs were received by Hamilton. Therefore, the information presented in the site description for Hamilton includes two months of data, experience, and planning on the part of Wesley Urban Ministries. Any data presented for the period prior to June 2011 refers data reported by the previously contracted service provider.

The RAP and CSS staff work from the 195 Ferguson Avenue North Hamilton Urban Ministries location. The Hamilton site operates in a hotel model and it utilizes the Hamilton Days Inn as the reception centre for the GARs. Figure 2 shows a map of the downtown east side of Hamilton, and identifies the locations of Wesley Urban Ministries, the reception centre, and two key health partners. All are located within walking distance of the Days Inn with the greatest distance being 600 metres.

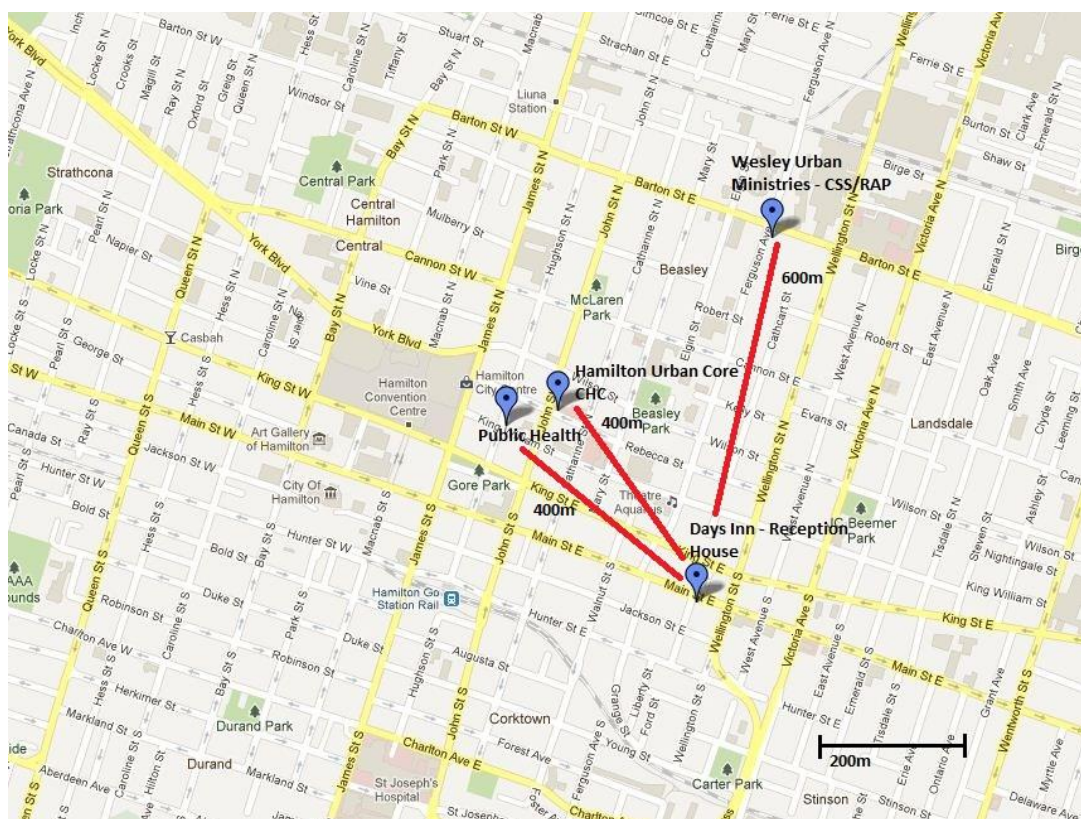


Figure 2: Map of Hamilton Site and Health Service Provider Partners

## Site Profile

Hamilton receives approximately 350 GARs annually. Figure 3 is a chart of the GARs arrivals in 2010. On average 34 GARS arrive each month as shown by the red line, however, this number fluctuates substantially August through January.

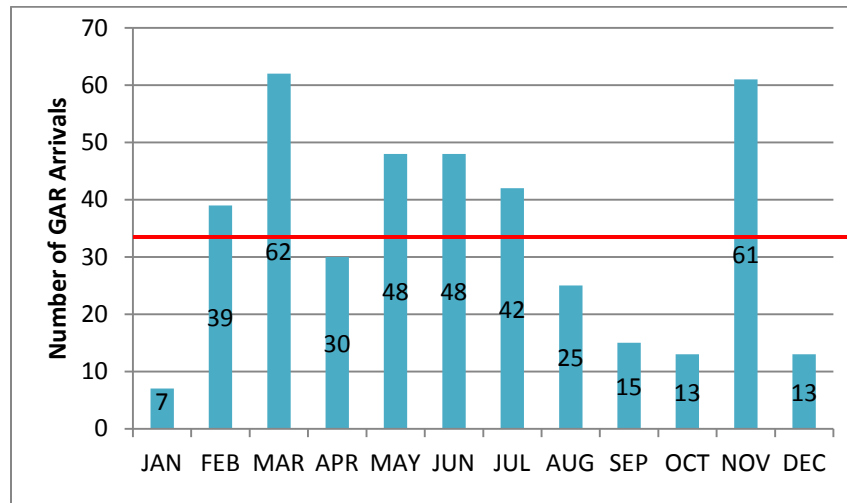


Figure 3: GARs Arrival to Hamilton (2010)

Due to the changes in the contracted service provider for RAP and CSS services, the age group information for the GARs in 2010/2011 was considered to be misrepresentative. It is therefore not provided in this section.

## Health Services

Wesley Urban Ministries has a partnership with the Hamilton Urban Core CHC to deliver initial health assessments and services as needed to GARs. This will be described further below.

The health needs by client in their first year from arrival in Hamilton are shown in Figure 4.

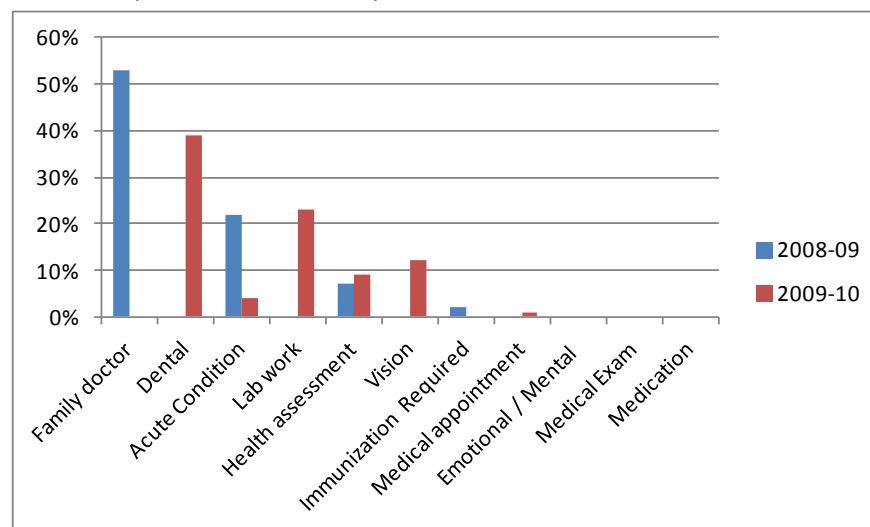


Figure 4: Health Needs of GARs in Their First Year in Ontario (2008-2010)

### *Planning*

When the Notice of Arrivals (NATs) arrive, they are reviewed by both RAP and CSS staff. If any health needs are flagged on the NATs, the RAP staff contacts the NP at the Hamilton Urban Core CHC to schedule times for those GARs with flagged health needs to be scheduled with her or one of the physicians at the next available time. If the needs identified on the NATs are more urgent than the available time of the physicians, the RAP staff arrange for those GARs to be taken to an urgent care clinic or the emergency room as needed upon or shortly after arrival. RAP staff and an interpreter, if necessary, accompany the GARs.

The RAP staff plan the GARs' orientation activities for their time at the reception centre and discuss these with the CSS staff. The RAP staff arrange health assessments for all arriving GARs with the Nurse Practitioner at Hamilton Urban Core CHC. Individual arrivals are seen at the CHC whereas for group arrivals the assessments are conducted in the Boardroom of the reception centre. These health assessments are scheduled within the GARs first week in Ontario.

### *Coordination and Provision of Health Services*

When the GARs first arrive they are greeted by RAP staff and shown to their accommodations. The RAP assessments are completed by the RAP staff within the GARs first 24 to 36 hours in at the reception centre. If any emergency or urgent health needs are identified through the RAP assessment, the GARs are taken to the hospital or urgent care clinic as needed. The GARs are accompanied by a RAP staff and an interpreter if necessary. If health needs are identified but do not require urgent care, the RAP staff would contact the NP at the Hamilton Urban Core CHC and schedule the GARs to be seen as promptly as possible.

The CSS assessment is undertaken within the first two weeks from the GARs' arrival. The RAP staff share the RAP assessment with the CSS staff to prevent redundancy and leverage any information already captured. If any health needs are identified either through the CSS assessment or during the GARs time at the reception centre the same approach as is described in the paragraph above is applied to arranging health services.

Within two days to one week of the GARs arrival, all GARs receive an initial primary care assessment with the NP from Hamilton Urban Core CHC. In addition to arranging these appointments, the RAP staff also arrange for Life Skills workers, trainers, or interpreters to accompany the GARs for the initial medical assessment depending on the needs of the GAR. Should there not be sufficient resource time of the NP, the GARs are taken to a walk-in clinic and are accompanied by Life Skills workers, trainers, or interpreters as needed.

Should follow-up from the initial medical assessment or a paediatric appointment be required, the CHC contacts the RAP staff to make arrangements. A paediatric clinic is run through the Hamilton Urban Core CHC Monday and Thursday of each week. Child GARs may be referred to the paediatric clinic by the NP. Similarly to the initial assessment, the RAP staff will inform the GARs and coordinate Life Skills workers, trainers, or interpreters to accompany the GARs as required.

Immunizations of individual GARs are provided by the NP at the Hamilton Urban Core CHC during the initial health assessment or follow-up. Should the GARs require immunizations that cannot be scheduled at the CHC, they are referred to other primary health providers. In the past, immunizations had been provided by Hamilton Public Health Services. However, this is no longer the case due to reported resource capacity limitations at public health. Group arrivals of GARs are an exception; immunizations and TB screening are provided by Hamilton Public Health Services nurses onsite in the boardroom of the reception centre.

All group arrivals of GARs with CIC protocols receive TB screening from Hamilton Public Health Services within their stay at the reception centre. The RAP staff schedule TB screening in conjunction with the immunizations which are done onsite in the boardroom of the reception centre. Individual GARs are screened for TB by the NP at Hamilton Urban Core CHC either in the initial assessment or in the follow-up, or were sent to Hamilton Public Health Services. Individual GARs appointments at Public Health are coordinated by the RAP staff and GARs are accompanied by Life Skills workers, trainers, or interpreters as necessary. Public Health follows up with all GARs who have been identified to have either active or latent TB. All follow-up appointments for immunizations and TB screening provided are at the Hamilton Public Health Services. Public Health contacts the RAP staff who make arrangements for the GARs to go to Hamilton Public Health Services for their appointments.

Should other health services be required, appointments are scheduled with the appropriate provider. While the GARs are living at the reception centre these services are arranged by the RAP staff. When the GARs have transitioned to their permanent residence, the CSS staff arrange for these health service appointments.

Wesley Urban Ministries has also entered into a partnership with Wilson Medical Centre, a Family Health Team in Hamilton, for additional health service provision. The Wilson Medical Centre has an emergency drug plan through which it provides prescribed drugs to those individuals who require them immediately. This plan is used by the Hamilton site when GARs arrive and have forgotten their prescriptions or they have run out of medication and it is required before the GARs can be seen at Hamilton Urban Core CHC. The Centre also runs a paediatric clinic to which GARs are referred if required. The Wilson Medical Centre has agreed to provide health promotion education to GARs while they are in their first year in Ontario, although this had not yet begun at the time of this study. These workshops will be coordinated through the CSS staff. Finally, the Wilson Medical Centre will enrol GARs as patients of the family physician until their roster is full.

## Partners

### Formal Partners

The Hamilton site has established a larger number of formal partnerships, in that it has signed service partnership agreements in place with its partners, than the other five sites. From the time when Wesley Urban Ministries was contracted by CIC, the Executive Director and RAP Manager solicited and began developing relationships with health service provider organizations that they felt would understand the GARs health needs and be willing to take on the challenges associated with providing services to GARS, such as billing IFH and addressing language barriers. The services provided by these organizations have been described in the Coordination and Provision of Health Services section above.

### Informal Partners

At the time of this project, Wesley Urban Ministries had a limited number of informal partners that it works with to provide health services to GARS.

The partner organizations and a brief description of their role and services are provided below.

Table 5: Hamilton Site Health Service Provider Partners

Organization	Role	Type	Description
<b>Hamilton Urban Core CHC</b>	Provide health assessments to all GARs and follow-ups	Formal	Hamilton Urban Core CHC has dedicated one of its NPs to provide health assessments to all GARs arriving at the Hamilton Site. Individual GARs are assessed at the CHC, however groups are assessed at the reception centre in the boardroom.
<b>Wilson Medical Centre</b>	Provide an emergency drug plan, health promotion, and family physicians	Formal	Wilson Medical Centre provides an emergency drug plan to supply GARs with prescriptions their medications when they cannot get them through the pharmacy. The Centre also provides health promotion such as education to GARs. Finally, the Centre will take GARs as patients of family physicians until such a time as their roster is full.
<b>Hamilton Public Health Services</b>	Public health information, TB screening, and immunizations	Informal	The Public Health Unit provides Wesley Urban Ministries with public health information in regards to GARs health issues when requested. It provides immunizations and TB screening on an as needed basis to GARs. When groups of GARs with a CIC health protocol arrive, the Public Health Unit sends nurse to deliver TB screenings and their readings onsite at the reception centre and provide immunizations.



## Challenges

As the Hamilton site had only just begun receiving GARs when this study was initiated, Wesley Urban Ministries had little experience with site specific challenges or promising practices to share. However, one of the challenges that was noted is that OHIP does not accept the reception house as a temporary address. Therefore, the GARs cannot apply for OHIP coverage until they move into their permanent residences; this is approximately 10 days after their arrival.

The effect of this delay in OHIP coverage is threefold. Providing assistance to GARs in applying for OHIP coverage is a result outlined in the RAP Schedule 1 of the SPO agreement, thereby the RAP staff have to extend services to GARs until they are in their permanent residence. This may involve providing mobile services that are not within the RAP staff responsibilities. Secondly, during this delay period GARs are ineligible for services that are covered by OHIP and not IFH. These services include, among others, services provide by the CCAC such as temporary health equipment and community support services. Thirdly, not having OHIP coverage makes it more difficult for RAP and CSS staff to find GARs family physicians or make appointments with specialists as there are a limited number of physicians and specialists that are registered with IFH.

## Promising Practices

Although Hamilton had only been awarded the contract for RAP and CSS shortly before this project was begun, the Executive Director and RAP Manager had engaged in discussions with a number of health service providers for the purpose of establishing service delivery partnerships. Wesley Urban Ministries had entered into two formal partnerships with Hamilton Urban Core CHC and the Wilson Medical Centre. Hamilton also has had discussions with Hamilton Public Health Services in relation to how to best provide immunizations and TB screening to GARs.

Through its formal partnership with Hamilton Urban Core CHC, the Hamilton site provides initial health assessments to all GARs within two days to one week of their arrival. The initial assessment with the NP allows for more efficient use of interpretation services and facilitates easiness of booking appointments (initial, follow-up, and referrals) for RAP staff. In addition, the CHC works with marginalized clients such as immigrants and refugees and are therefore the CHC providers are aware of health issues specific to these populations.

Finally, the service partnership agreement that Wesley Urban Ministries has with Hamilton Urban Core CHC ensures that the services are not depended on personal relationships. Most of the six GARs receiving sites have informal partnerships with organizations that provide health services, however the partnerships are typically between the site and an individual service provider within the organizations as opposed to the organizations themselves. As a result, there is a risk that the partnerships may collapse should any of the individuals leave the organization. Formal partnerships ensure the succession of the partnership in the event that the individuals who began them are no longer involved. That is not to say that the informal partnership or individual relationships are not important, indeed, they are often the foundations of the most promising partnerships.

## Kitchener-Waterloo

### Context

The Kitchener-Waterloo RAP and CSS services are contracted through Reception House Waterloo Region. In 2009, the organization name was changed from Kitchener Waterloo House Church Assembly to Reception House Waterloo Region. The organization has been contracted by CIC since 1988 to provide RAP services. CSS services have been operational in Kitchener-Waterloo since 2007/2008.

The Reception House is located at 101 David St in the heart of downtown Kitchener. Both the RAP and CSS staff offices are located at the Reception House. GARs reside at the Reception House for approximately 13 to 18 days until they move to their permanent residences.

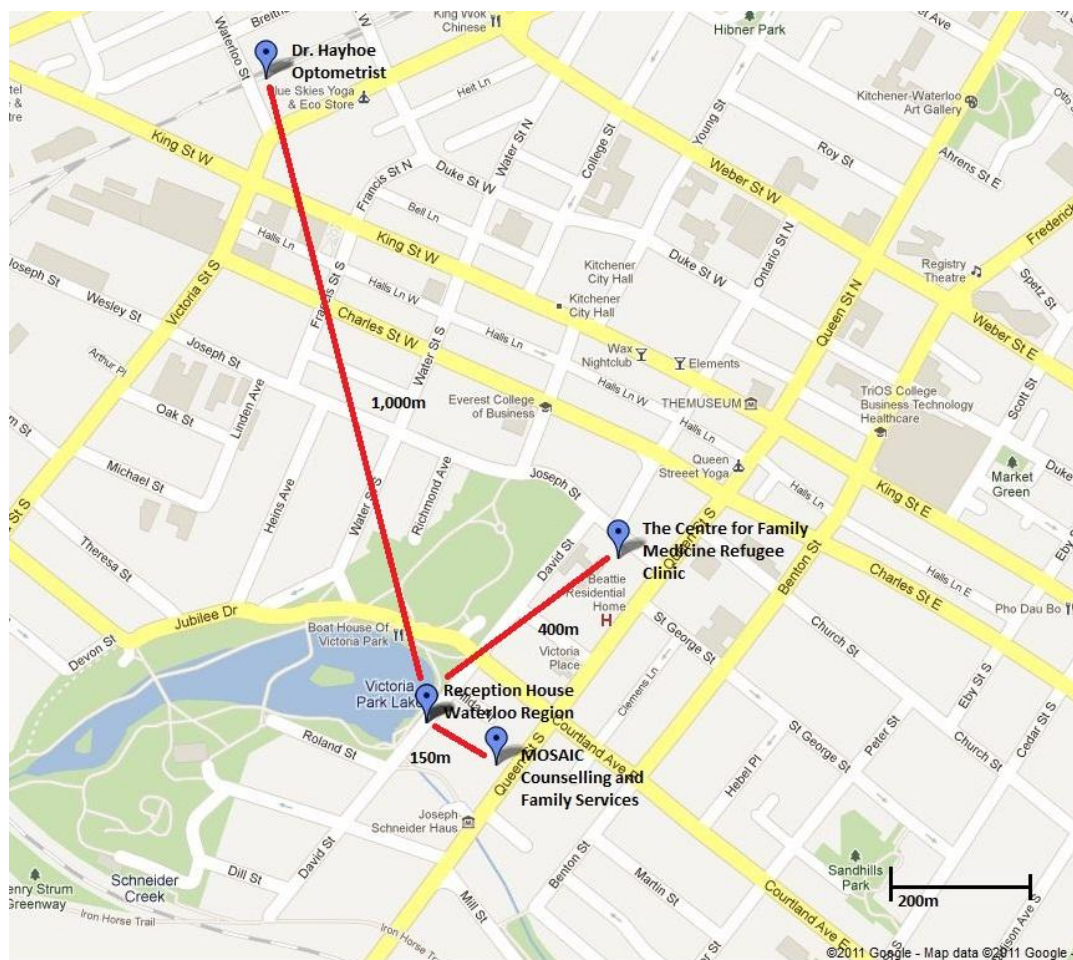


Figure 5: Map of Kitchener Waterloo Site and Health Service Provider Partners

Figure 5 is a map of Kitchener showing the Reception House along with the key health partners and their physical orientation relative to the Reception House.



## Site Profile

Kitchener-Waterloo receives approximately 300 GARs annually. Figure 6 is a chart depicting the monthly arrivals of GARs in 2010, with the average number of GARs arriving each month, 25, shown in red. As can be seen in Figure 6, the arrival of GARs to the Kitchener-Waterloo is cyclical with peaks occurring in the spring and fall and valleys in the summer and winter.

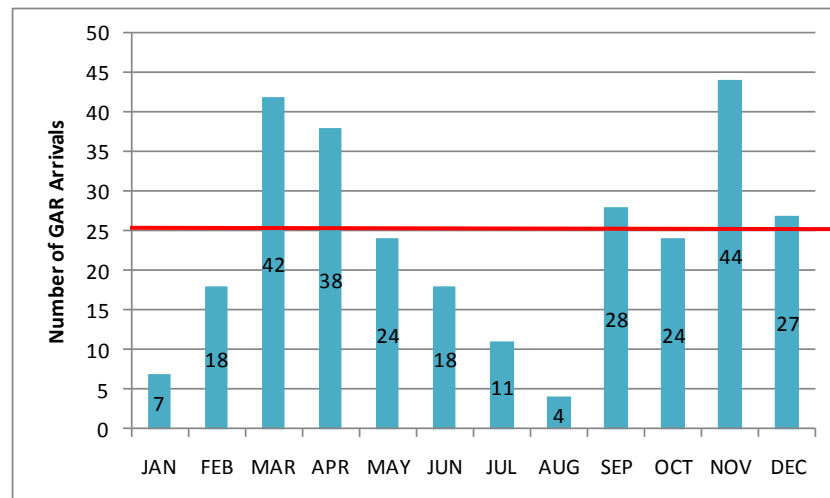


Figure 6: GARs Arrivals to Kitchener Waterloo (2010)

Figure 7 shows the GARs arriving to Kitchener-Waterloo each year by age group and the percentage of health needs by age group. The GARs arriving in Kitchener-Waterloo are almost split evenly into age groups of children, youth, and adults which is distinct from the other five sites in that they commonly have a greater proportion of adults. The health needs of GARs are spread evenly across the age groups; there are no age populations for whom there are greater health needs identified than any other.

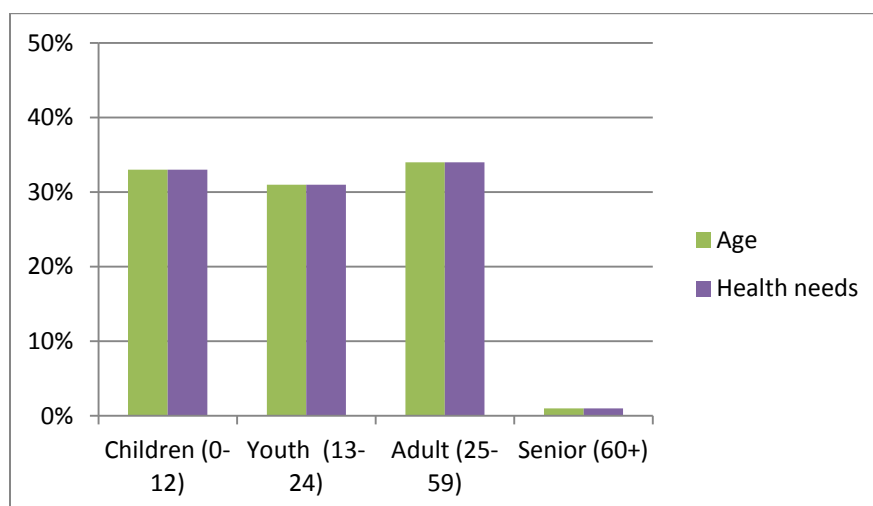


Figure 7: GARs Age and Health Needs (2010)

## Health Services

The Reception House has a partnership with the Centre for Family Medicine Refugee Clinic (Refugee Clinic) for the provision of health assessments and follow-up appointments. In addition, the Reception House is currently partnering with MOSAIC to provide mental health services to GARs.

Figure 8, below shows the health needs of GARs in their first year after arrival at the Kitchener-Waterloo site.

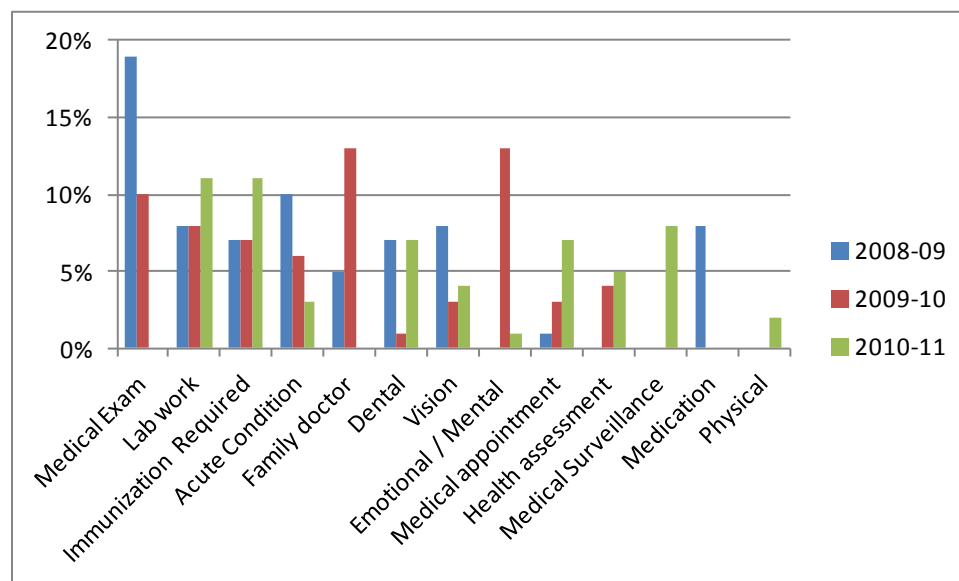


Figure 8: Health Needs of GARs in Their First Year in Ontario

## Planning

When the NATs arrive, they are reviewed by both RAP and CSS managers. If any urgent health needs are flagged on the NATs, the RAP staff arrange for those GARs to be taken to an urgent care clinic or the emergency room as needed upon or shortly after arrival. RAP staff and an interpreter, if necessary, accompany the GARs.

The RAP and CSS staff plan the GARs orientation activities together based on the needs of the GARs. At the Kitchener-Waterloo site the work of the RAP and CSS staff is collaborative and much of the work of the CSS staff while the GARs are at the Reception Centre is focused on health services. The CSS Manager reports that the estimated proportion of time that a CSS worker spends on assisting GARs to access health services is 80% as these services are not provided by through the community. The CSS staff arrange health intakes and assessments for all arriving GARs with the Refugee Clinic and MOSAIC. These health assessments are scheduled within the GARs first week in Ontario.

### *Coordination and Provision of Health Services*

When the GARs arrive at the Reception House they are shown their accommodations. Within 24 hours of their arrival the RAP workers engage in a “meet and greet” and carry out the RAP intake assessment. Ideally the CSS intake assessment would occur immediately thereafter but may be conducted up to 24 hours after the RAP intake assessment. Based on the NAT and the CSS assessment the CSS Manager will liaise with the Refugee Clinic and MOSAIC regarding any immediate needs a GAR may have. If it is determined that those needs must be addressed immediately, appointments with the appropriate health service partners are made. Similarly, if needs for allied health services such as dental or optometry are identified appointments to address these would also be arranged.

Within their first week at the Reception Centre all GARs undergo a health assessment. This assessment is conducted in two parts. In the morning a multidisciplinary team does an intake at the Reception Centre. The team includes a nurse and a resident from the Refugee Clinic, a social worker from MOSAIC, and an interpreter and/or the CSS worker. During this time a medical history is taken, and the social worker observes the interaction; if counselling services are needed the social worker requests a referral for a social work assessment for the GAR. In the afternoon, the GARs go to the Refugee Clinic to continue with the health assessment. The health providers at this health assessment consist of a nurse, resident, physician (currently Dr. Neil Arya), and interpreter or case worker if necessary. The same nurse and resident from the morning’s intake conduct the health assessment under the supervision of Dr. Arya. (In the event that Dr. Arya is unavailable plans are made for another physician to perform this role.) A protocol is used for these appointments, that was developed by the Refugee Clinic; it involves a review of the morning intake, and blood work and stool samples (if necessary), along with a full health assessment. The blood work and stool samples are conducted at a lab and the appointments are arranged by the CSS workers and either a case worker or an interpreter accompanies the GARs.

In addition to the health assessment, all GARs go to the Region of Waterloo Public Health for immunizations. If the GARs are part of a group for whom CIC has developed a medical protocol (e.g., the Karen or the Bhutanese), TB screenings are undertaken. For all individual GARs, Public Health conducts TB screening at the Reception House two to three times per year. Public Health then follows up with those GARs that were identified as requiring treatment based on the screening.

Also, as noted earlier, if other health service needs are identified, appointments are arranged with the appropriate providers. These health service needs may be identified in the health assessment or by RAP or CSS staff. These needs are typically addressed by a group of allied health service providers including dentists, optometrists, and specialists.

Currently, MOSAIC and the Reception House are engaged in a pilot study for the provision of mental health services to GARs. As previously mentioned, if mental health needs are identified during the medical assessment by the MOSAIC social worker, appointments are arranged with a MOSAIC social worker for further assessment. If GARs are identified as candidates for further mental health counselling, 30 hours of counselling are provided under the pilot study. This counselling takes the form

of one-on-one or group (mostly family) counselling that may take place either at the Reception House or at MOSAIC.

Follow-up appointments are also provided to all GARs at the Refugee Clinic. If something that requires follow-up is identified in the initial health assessment a follow-up is conducted one to two weeks after the health assessment. Should nothing specific be identified in the initial medical assessment, all GARs are scheduled for a follow-up appointment at the Refugee Clinic within a month of the initial health assessment. These appointments are arranged by the Refugee Clinic and CSS staff.

It is of note that at any time in the process where emergency or urgent care needs are identified by either the RAP or CSS staff the GARs would be taken to the emergency room or an urgent care clinic as appropriate. RAP staff is responsible for emergency and urgent care needs while the GARs reside at the Reception House and CSS staff are responsible when the GARs have transitioned to their permanent accommodations. Because of the one-off nature of these activities they are not noted on the process map or in this narrative.

## Partners

### *Formal Partners*

In regards to the health services provided to GARs, the Reception House has almost no formal partnerships. The only formal partnership is that with MOSAIC under the pilot study.

### *Informal Partners*

The Reception House has a large number of informal partners. These partners range from health providers to mental health service providers to specialists to allied health service providers.

The strongest informal partnership exists with the Region of Waterloo Public Health (Public Health) for the provision of TB screening and immunizations when population groups of GARs for which CIC has developed protocols arrive. Thus far, all protocols developed by CIC have required immunizations and TB screening that is conducted by public health. However, when individual GARs arrive, immunizations are arranged at the public health unit by CSS workers. TB screening is conducted as described in the Coordination and Provision of Health Services section above.

Below is a table of the health partners of the Reception House, their roles, and brief descriptions of the services offered.

Table 6: Kitchener-Waterloo Health Service Provider Partners

Organization	Role	Type	Description
<b>MOSAIC</b>	Mental health assessment and counselling	Formal	Provide mental health assessments and counselling to GARs as appropriate/referred. Currently engaged in a pilot project for the above services.
<b>The Centre for Family Medicine Refugee Clinic</b>	Primary health care	Informal	The relationship with the Refugee Clinic is through Dr. Neil Arya who specializes in Global Health. Although the relationship is well established, there is no formal service partnership agreement between the two organizations. The Refugee Clinic provides initial health assessment to each GAR arriving in Kitchener-Waterloo. The Refugee Clinic services are billed through OHIP.
	Provide residents for initial health intake and assessment program	Informal	McMaster family residency students that are under the supervision of Dr. Arya conduct initial health intakes at the Reception Centre and the initial health assessment at the Refugee Clinic.
<b>Centre for Family Medicine Pharmacy</b>	Provide prescriptions to GARs and medication information	Informal	There is a pharmacy in the Centre for Family Medicine that provides the majority of the GARs prescriptions. The pharmacy is familiar with IFH approvals and billings.
<b>Region of Waterloo Public Health</b>	Provides immunizations and TB screening	Informal	All GARs are provided TB screening by Public Health. Public Health provides clinics two to three times per year at the Reception House. All GARs are sent to Public Health to receive immunizations as needed. In the case of group arrivals of GARs for whom CIC has provided protocols, Public Health will send nurses to the Reception House to provide immunizations and TB screening.
<b>Dr. Hayhoe</b>	Provides optometry services	Informal	Dr. Hayhoe provides optometry services to GARs. He is familiar with IFH billing and working with interpreters. In addition, Dr. Hayhoe is familiar with GARs visual health issues, from a global health perspective. Dr. Hayhoe supervises residents of the University of Waterloo optometry school and therefore educates them as to GARs visual health issues and working with IFH and interpreters.
<b>Allied health service</b>	Provide allied health services	Informal	The Reception House has established a network of allied health professionals that provide services to

<b>providers</b>			GARs. These allied health providers are familiar with IFH and GARs health issues.
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### Challenges

Although the Reception House has been successful thus far in attaching GARs to family physicians, it was reported to be one of the greatest challenges experienced by the site. There is a perceived shortage of family physicians in Kitchener-Waterloo that makes it difficult to place GARs. In addition, it is reported that it is more difficult to find family physicians willing to take on GARs as patients because of language barriers and the perception that GARs experience a greater number of health issues than other clients.

Language barriers were cited as a challenge for Kitchener-Waterloo. This was reported to be both due to a lack of “qualified” interpreters and a lack of funds for health care specific interpretation. Kitchener-Waterloo is one of the smaller cities receiving GARs in Ontario and it was stated that for this reason there is a shortage of interpreters for some languages and also at those times or months when a high number of GARs. Although Kitchener-Waterloo is relatively close to Toronto, it is inconvenient and expensive to have to import interpreters from Toronto for services. Although, IFH will provide funding for interpretation of health services for GARs, funding is often not provided in health service agencies and organizations such as public health settings and hospitals.

### Promising Practices

In Kitchener Waterloo, all GARs receive an initial health assessment within their first week of arrival in Ontario. This is reported to result in better health outcomes for GARs both in the short-term and long-term. The partnership that the Reception Centre has with the Centre for Family Medicine Refugee Clinic is beneficial for numerous reasons. The Refugee Clinic is close in proximity to the Reception House and therefore GARs, RAP and CSS staff can walk back and forth as necessary. There is a pharmacy onsite at the Centre for Family Medicine allowing timely provision of medication by staff that are familiar with IFH services and billing. Further, the relationship with the Refugee Clinic includes the residency program which provides additional services such as the initial health intake with no charge to OHIP or the Reception Centre, with the exception of the provision of interpretation services. This both provides GARs greater exposure to the health system and also provides future physicians the opportunity to learn about GARs health needs and the cultural competence required for service delivery. Finally, Dr. Neil Arya is an expert in global health and therefore an ideal provider from whom to leverage knowledge and health services.

The mental health services pilot with MOSAIC has been reported to have beneficial effects on GARs. Again, MOSAIC is in close proximity to the Reception House increasing the ease of access to their services. Also, the partnership enables MOSAIC to provide service providers more efficiently, to participate in the initial health intake and to provide ongoing mental health services. The types of services (i.e., not traditional talk therapy) offered to GARs through MOSAIC have been noted as being effective.

The Reception House, particularly the CSS Manager, has established a strong network of health service providers. On a regular basis, the Reception House will bring together health service providers to discuss issues relevant to the provision of health services to GARs such as IFH registration and billing, pertinent health issues, and to case manage GARs with high priority complex health needs.

Finally, RAP and CSS staff in Kitchener-Waterloo are highly collaborative. Not only do the staff work in close proximity to one another and therefore interact frequently, but also they share the responsibility for the planning and delivery of health services. This is reported to result in greater continuity and quality of health services to the GARs. In addition, it results in greater efficiency and effectiveness for health service providers when they are providing services or relaying information to RAP and/or CSS staff and/or GARs.



## London

### Context

The RAP and CSS programs in London are provided through the London Cross Cultural Learning Centre (LCCLC). The LCCLC has been contracted through CIC to provide RAP services since 1998. The CSS program in London was the last to be rolled out in Ontario; it was operational in 2008/2009 one year after at the other sites.

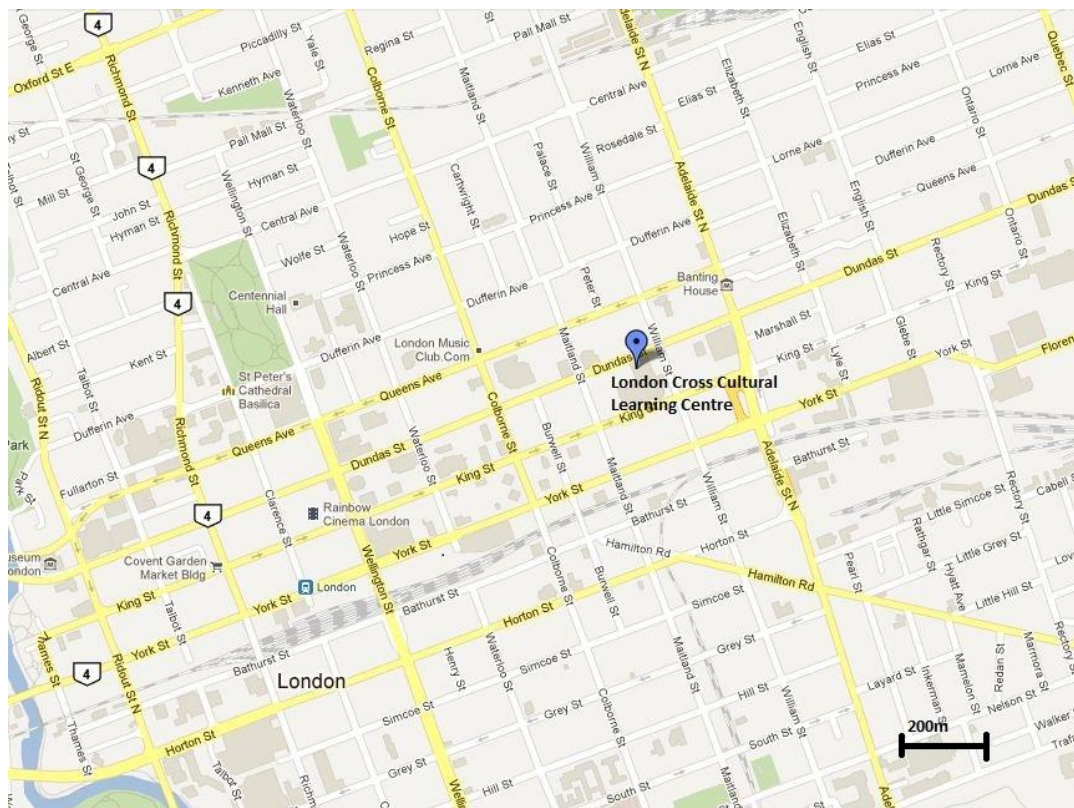


Figure 9: Map of London Site and Health Service Provider Partners

The LCCLC is located at 505 Dundas Street in London. The LCCLC location houses the RAP and CSS staff, the reception centre, and the Refugee Health Clinic. GARs reside at the reception centre for approximately 15 days on average before they move to their permanent residences. The LCCLC can be seen in Figure 9. As the GARs health services, reception centre, and RAP and CSS offices are all located at the same address in downtown London, it is the only site marked on the map.

### Site Profile

London receives approximately 229 GARs annually. Figure 10 is a chart depicting the monthly arrivals of GARs in 2010. The average number of GARs arriving each month, 20 is shown in red. The arrival of GARs in London is fairly consistent throughout the year; however in 2010 there was a significant spike in the number of arrivals in March.



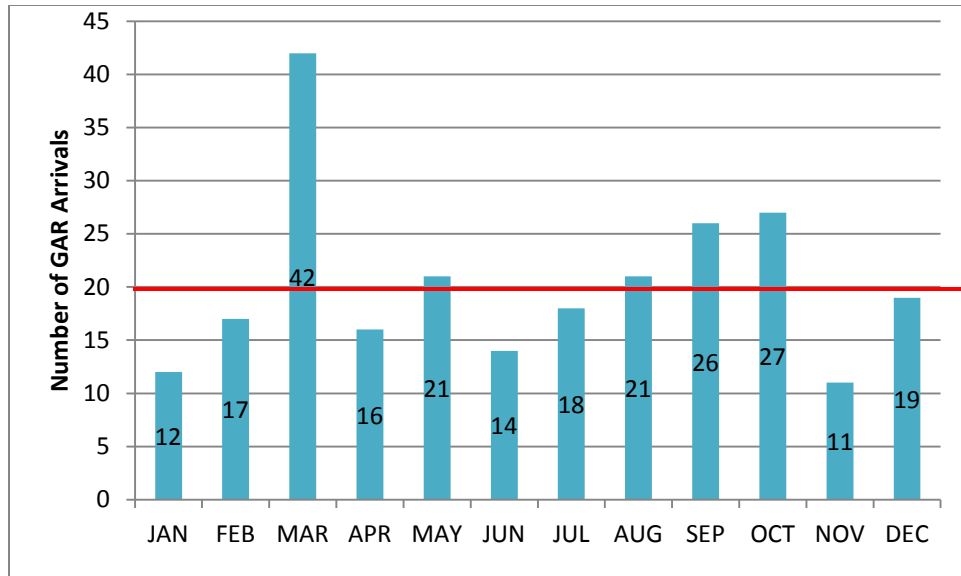


Figure 10: GAR Arrivals in London (2010)

Figure 11 shows the arrival of GARs in 2010/2011 by age group and health needs. As can be seen, the greatest age group of GARs is adult. The health needs of GARs by age group are proportionate to the size of the age group. The average number of identified health needs per GAR in London is three. With seniors requiring the greatest health needs for their age group.

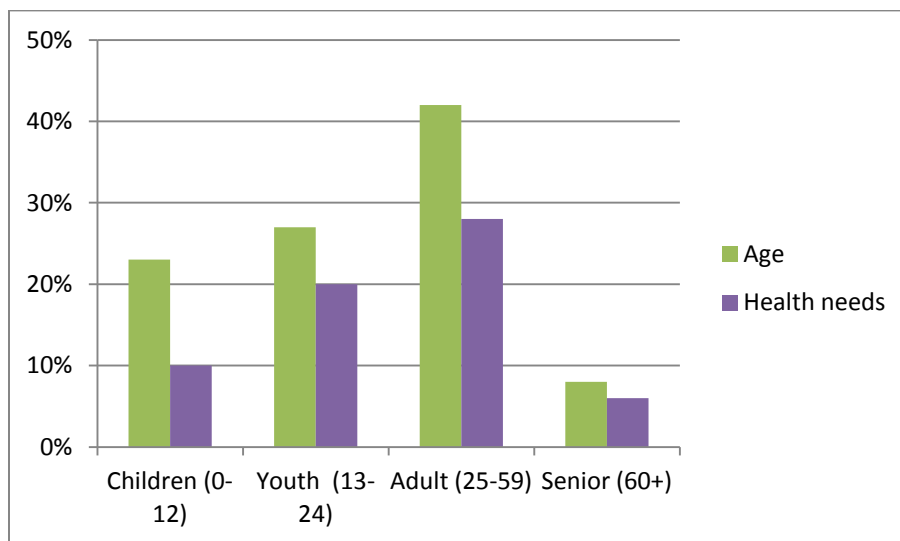


Figure 11: GARs Age and Health Needs (2010)

## Health Services

Figure 12, below shows the health needs of GARs at the London site in their first year in Ontario.

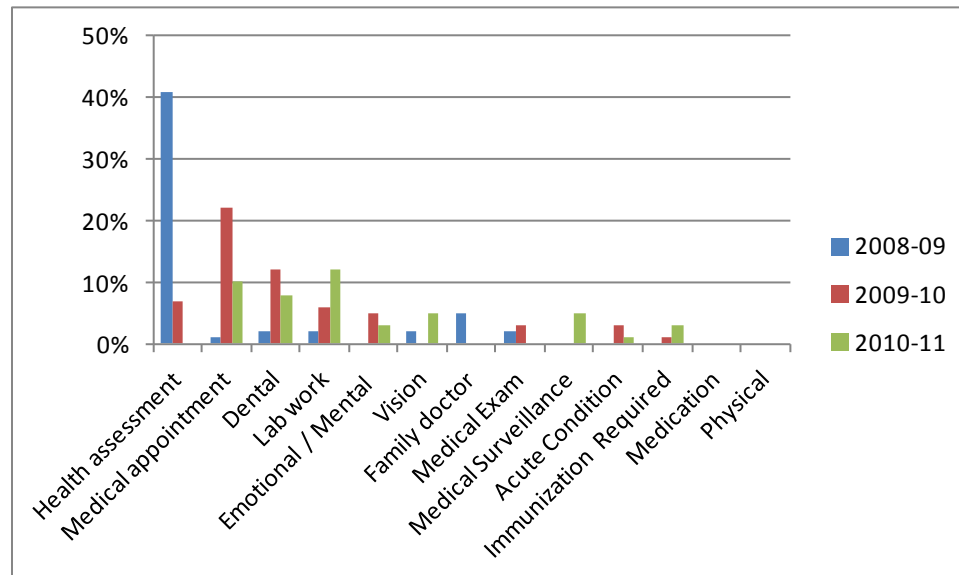


Figure 12: GARs Health Needs in Their First Year in Ontario (2008-2011)

## Planning

When the NATs arrive they are reviewed by both the RAP and CSS staff. The LCCLC has a health coordinator, who is one of the CSS staff, and who in addition to her role providing CSS case management, also coordinates services related to GARs health needs. The health coordinator arranges times for the GARs with health needs flagged on the NATs to be scheduled with physicians at the Refugee Health Clinic as soon as possible. If the needs identified on the NATs are urgent and physician time is not available at the Refugee Clinic, while the GARs are living at the reception centre the RAP staff arrange for them to be taken to an urgent care clinic or the emergency room. RAP staff and an interpreter, if necessary, accompany the GARs.

The RAP staff plan the GARs' orientation activities for their time at the reception centre and discuss these with the CSS staff. The health coordinator works with the RAP staff to arrange health assessments at the Refugee Health Clinic for the arriving GARs. Those GARs with higher priority health needs are booked in earlier than those with lower priority needs.

## Coordination and Provision of Health Services

When the GARs first arrive, they are greeted by the RAP staff and shown their accommodations. The RAP assessments are completed by the RAP staff within the GARs first 24 hours at the reception centre. If any emergency or urgent health needs are identified through the RAP assessment, the GARs are taken to the hospital or urgent care clinic and are accompanied by RAP staff and an interpreter, if necessary and if one is available. If health needs are identified but do not require urgent care, the RAP staff liaise with the health coordinator to book the GARs at the Refugee Health Clinic as promptly as possible.

The CSS assessment is conducted between the second and tenth day after the GARs arrival. The RAP staff share the RAP assessments with the CSS staff so that they have access to any information required for the CSS program that has already been collected. If any health needs are identified either through the CSS assessment or during the GARs time at the reception centre the same approach as is described in the paragraph above is applied to arranging health services.

Only those GARs who are identified with high health priority needs based on their NATs or by RAP or CSS staff and those for whom CIC has created health protocols are seen in the Refugee Health Clinic during their time at the reception centre. The Refugee Health Clinic is located on the third floor of the LCCLC. It operates one to two times per week or one to two times per month depending on the number of GARs arriving at the reception centre and the availability of the physicians. During the school year, the Refugee Health Clinic works with the Newcomer Health Project. Newcomer Health Project is run in collaboration with the University of Western Ontario (UWO) Schulich School of Medicine. Second year medical students, under the supervision of the physicians at the Refugee Clinic, review the clinical history of the GARs with them and generate a medical history, and do a health assessment of the GARs. There is annual training provided to UWO students who volunteer for the Newcomer Health Project by the LCCLC and the Refugee Health Clinic physicians. The physicians of the Refugee Health Clinic have developed a protocol for health assessments of GARs that is used by all medical students and physicians. During the students summer break the physicians take the medical history and the health assessment. The medical history is transferred to the GARs' family physicians once they are attached. If interpretation is necessary it is arranged by the health coordinator when the appointments are booked.

If anything comes to light during the health assessment, the GARs are scheduled and seen for a follow-up appointment. The follow-ups are scheduled with the assistance of the health coordinator and/or the CSS staff.

Following the refugee health assessment the CSS staff attempt to attach the GARs to family physicians. If the GARs require health services in their first year in Ontario and have not been able to find or be attached to a family physician, the physicians at the Refugee Health Clinic will continue to see them.

If the GARs require TB screening or immunizations they are sent to the Middlesex-London Health Unit. LCCLC has a strong relationship with Public Health and the CSS program manager emails requests for appointments to them as necessary. When Public Health provides information to the LCCLC, it is emailed to the Program Manager for distribution to the CSS staff. For those groups of GARs where CIC health protocols are in place, Public Health has sent nurses to the LCCLC to perform TB screening and immunizations onsite.

The LCCLC and the London InterCommunity Health Centre (LIHC) have partnered to provide to two health programs to GARs. Both programs are run onsite at the LCCLC by staff from LIHC. The diabetes health management group meets every other week and is specifically oriented to Karen and Arabic GARs. *Women of the World* is a group for female GARs with the goal of creating a support network. At the time this project was conducted, there was one *Women of the World* group for Iraqis and one was being planned for the Karen.

While it is not a regular provider of services, an additional external health service provider of note is the local pharmacy. The LCCLC and the pharmacy have established a strong relationship. The pharmacy is a registered IFH provider and is willing to bill IFH for prescriptions dispensed to the GARs. Further, the pharmacists will provide interpretation should it be dispensing multiple prescriptions to an individual to ensure the information is understood. Finally, the pharmacy will delivery medications to the reception centre.

## Partners

### Formal Partners

While the LCCLC has no formal partners with whom it has signed service provision agreements, the Refugee Health Clinic and Newcomer Health Project are formal programs of the LCCLC that are based on strong relationships with physicians in the community.

#### The Refugee Health Clinic and Newcomer Health Project

The Refugee Health Clinic was begun in 2008 with a single physician. The clinic originally ran one morning per week. In addition to providing health services to GARs, the physician brought in second year medical students from the UWO and had them prepare and give presentations to the GARs on health issues. Since that time the clinic has expanded to three physicians, two family physicians, and an emergency room physician. In addition, the UWO students conduct the medical history as described in the Health Services section above.

The physicians at the Refugee Health Clinic generally bill IFH for services provided to the GARs that are seen. This is due to the challenges that the GARs have in gaining approval for OHIP coverage while they are living at the reception centre. This is described further in the Challenges section below. The students donate their time.

### Informal Partners

The LCCLC has a number of informal partners that it works with to provide health services to GARs.

The partner organizations/individuals, and brief descriptions of their roles and services are provided below.

Table 7: London Site Health Service Provider Partners

Organization	Role	Type	Description
<b>Refugee Health Clinic Physicians</b>	Provide health assessments and follow-up to GARs	Informal	The physicians provide health assessments to all GARs and primary care services as required onsite at the reception centre in the Refugee Health Clinic.
<b>Middlesex-London Health Unit</b>	Public health information, TB screening, and immunizations	Informal	The Public Health Unit provides LCCLC with public health information about GARs health issues when requested by the LCCLC. It provides immunizations and TB screening on an as needed basis to GARs. When groups of GARs with a CIC health protocol arrive, the Public Health Unit sends nurses to deliver TB screenings and their readings and provide immunizations onsite.
<b>London InterCommunity Health Centre</b>	Provides health promotion to GARs	Informal	LIHC provides specific health promotion groups for GARs provided onsite at the LCCLC.
<b>University of Western Ontario</b>	Provides second year students for the Newcomer Health Project	Informal	Technically, UWO's agreement is with the physicians that deliver services at the Refugee Health Clinic. UWO provides second year students that are supervised by these physicians and who provide clinical histories onsite at the Refugee Health Clinic
<b>Shoppers Drug Mart</b>	Provides medications and prescriptions	Informal	The local Shoppers Drug Mart registered with IFH so that it might provide medications to GARs. Further, when there are multiple prescriptions issued to an individual, the pharmacy will provide interpretation to ensure that there is no confusion in dispensing the medications.
<b>Muslim Resource Centre</b>	Mental health services and family counselling	Informal	The Muslim Resource Centre provides mental health services and family counselling to GARs as referred to the organization. The staff provide services in Arabic that are culturally sensitive.
<b>Regional HIV/AIDS Connection</b>	HIV/AIDS services and education	Informal	The LCCLC refers all GARs diagnosed with HIV/AIDS to the Regional HIV/AIDS Connection. The organization provides general education sessions and weekly counselling for referred individuals.

## Challenges

Procuring OHIP coverage for the GARs during their time at the reception centre is a challenge for the LCCLC. The OHIP office will not accept the LCCLC as a temporary address when the GARs apply for OHIP coverage. Therefore, the GARs cannot apply for OHIP coverage until they move into their permanent residences. In London, this is on average 15 days after the GARs arrive in Ontario.

The effect of this delay in OHIP coverage is twofold. As RAP staff are obliged to support GARs to obtain OPIP coverage as outline in the RAP Schedule 1 of the SPO agreement, the RAP staff have to extend services to GARs until they are in their permanent residence and OHIP coverage has been secured. This may involve providing services that are not within the RAP staff responsibilities. Secondly, as the delay can be anywhere from six weeks to two months, during this period GARs are ineligible for services that are covered by OHIP and not IFH. These services include services provide by CCAC such as temporary health equipment and community support services.

## Promising Practices

The LCCLC ensures that all of the GARs receive a standard health assessment during their first two months in Ontario at the third floor physicians' clinic of the LCCLC (Clinic). It is beneficial to GARs with urgent health needs that these services are provided onsite while they are at the reception centre because it is easier for follow-up appointments and referrals to be arranged if necessary. As part of the health assessment protocol a medical history is taken and mental health is a component of both the history and the assessment. Therefore mental health needs can be addressed in a timelier manner. The medical history is sent with the GARs to family physicians with whom they are attached.

The Newcomer Health Project leverages the local university and its medical school to provider free health services to GARs. The opportunity to work with GARs early in their medical education provides medical students with an enhanced education. Students not only learn how to work with interpreters, bill IFH, take clinical histories, but also learn about global health issues and GARs specific health issues.

Further, for those GARs that cannot find or become attached to a family physician during the first year in Ontario, the Clinic will continue to provide health services during that time. This ensures that if there are health issues that present themselves over the course of the year that they might be addressed in a timelier manner.



## Ottawa

### Context

The RAP and CSS services are contracted through the Catholic Immigration Centre. The organization has been contracted with CIC since 1998 to provide RAP services. The CSS services have been operational in Ottawa since 2007/2008.

The reception centre and the RAP offices are located in the same building at the Reception House (Maison Therese Dallaire) at 204 Boteler Street. The CSS offices are located at the Catholic Immigration Centre head office at 219 Argyle Avenue. The map in Figure 13 depicts the location of the Reception House and its formal health partner the Wellness Centre. In addition, the Ottawa Public Health Sexual Health Clinic is depicted.

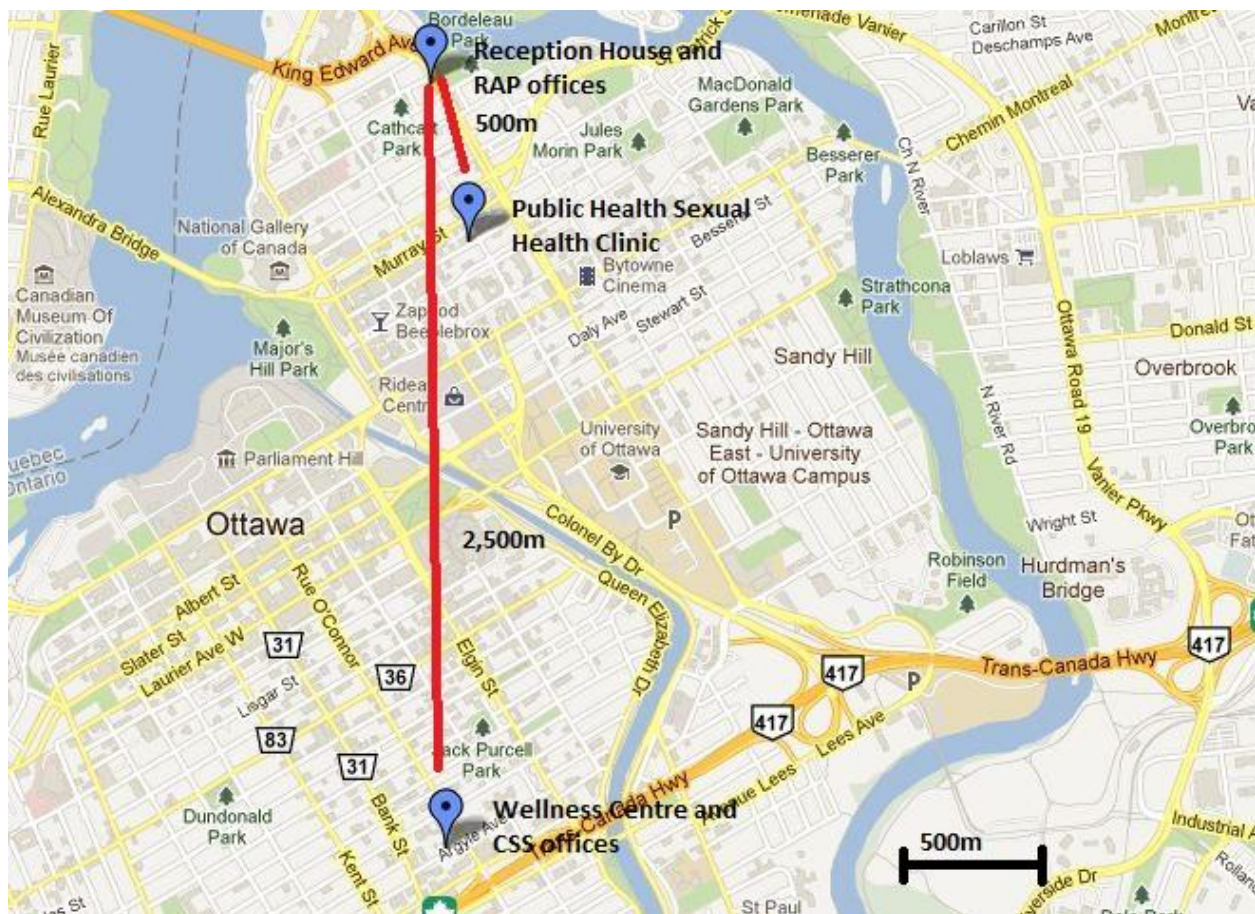


Figure 13: Map of Ottawa Site and Health Service Providers Partners

## Site Profile

Ottawa receives approximately 375 GARs annually. In 2010, Ottawa received 371 GARs as is shown in Figure 14. The average number of GARs arriving each month is 40, noted by the red line. Although, the arrival of GARs to Ottawa is variable, it is not cyclic, as some of the other sites are, with peaks in the spring and fall. The number of GAR arrivals in June is evidently an outlier with 90 GARs arriving that month, as is January with the arrival of only one GAR.

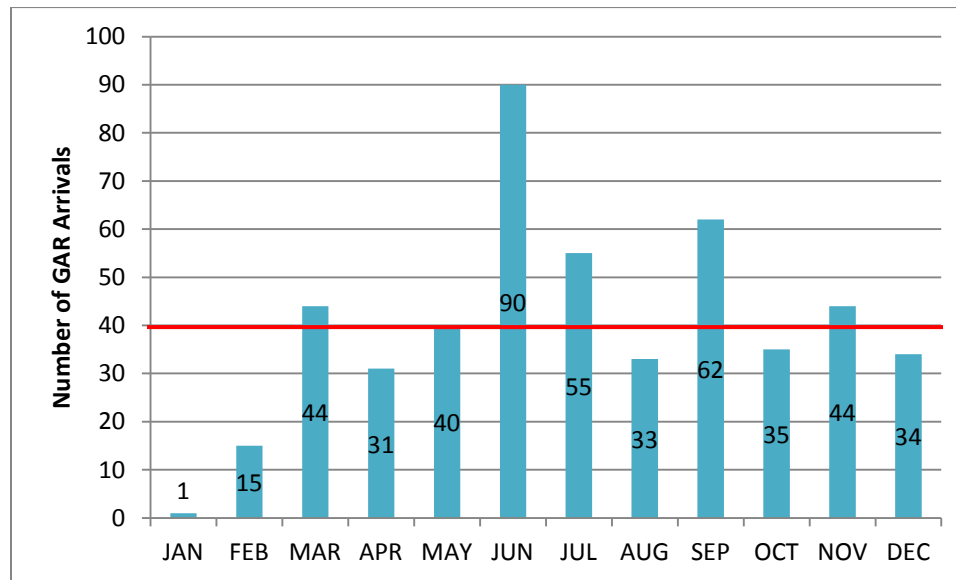


Figure 14: GARs Arrivals in Ottawa (2010)

The rate of health needs by age group is shown in Figure 15. The distribution of health needs by age group is reflective of the distribution of age groups in Ottawa. The adult age group, aged 25-59, however, have the highest percentage of health needs. The average number of health needs per GAR in Ottawa is two, just under the provincial rate of three.

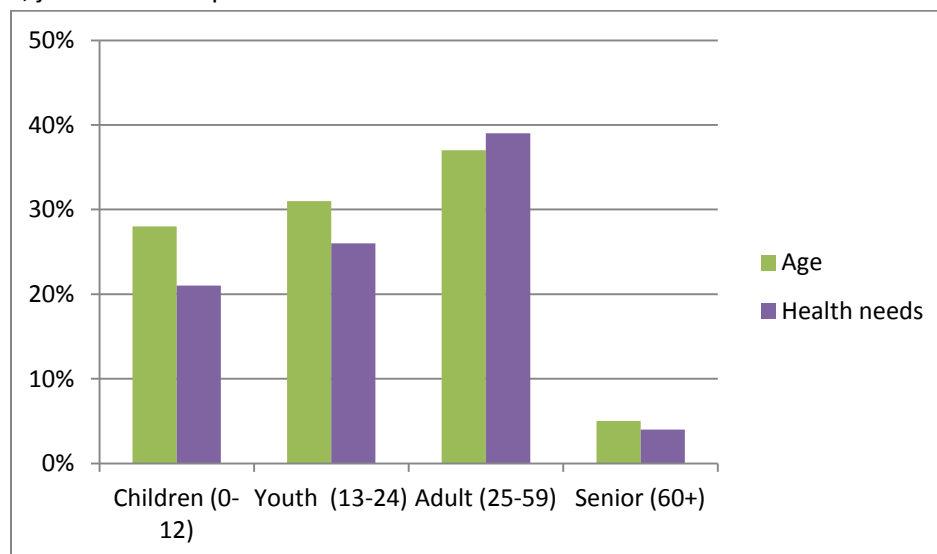


Figure 15: GARs Age and Health Needs (2010)



## Health Services

The figure below shows the health needs of GARs in their first year after arrival in Ottawa.

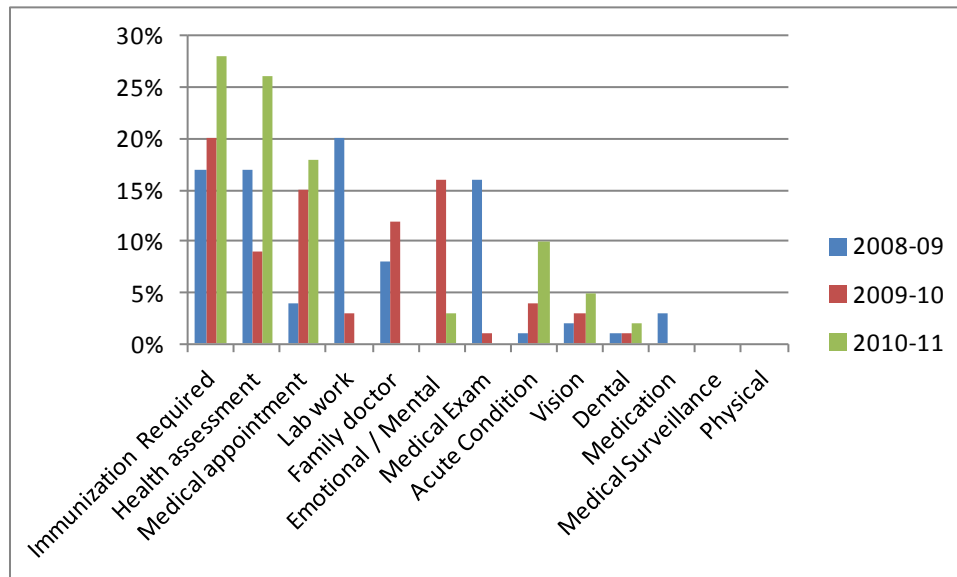


Figure 16: GARs Health Needs in Their First Year in Ontario (2008-2011)

## Planning

When the NATs arrive they are reviewed by both the RAP and CSS staff. If any health needs are flagged on the NATs, the RAP staff relay the NAT to the health coordinator. The health coordinator is an employee of the Somerset West Community Health Centre (SWCHC) that is the Catholic Immigration Centre's formal health partner. This partnership will be described further in the section on Formal Partners below. The health coordinator arranges appointments for those GARs with flagged health needs to be scheduled with one of the physicians at the Wellness Centre at the next available time. If a physician is not available to address the needs identified on the NATs in a timely way, the RAP staff arrange for those GARs to be taken to an urgent care clinic or the emergency room upon or shortly after arrival. RAP staff and an interpreter, if necessary, accompany the GAR.

The RAP staff plan the GARs' orientation activities for their time at the reception centre and discuss these with the CSS staff. As part of orientation activities while the GARs are at the reception centre, the RAP staff coordinate for medical histories to be taken. This is accomplished through a program called the Health Advocacy for Refugees Program (HARP). HARP is provided from September through May by students and a supervising professor from the University of Ottawa medical school.

Planning for health assessments for each of the GARs is done by the CSS staff. These appointments are scheduled at the Wellness Centre through the health coordinator and they are scheduled from 15 days after the arrival of the GARs onward. Those GARs with higher priority health needs are booked in earlier than those with lower priority needs. CSS staff also ensure that interpreters are scheduled as appropriate for these appointments.

### *Coordination and Provision of Health Services*

When the GARs first arrive they are greeted by the RAP staff and shown their accommodations. The RAP assessments are completed by the RAP staff within the GARs first 24 to 36 hours at the reception centre. If any emergency or urgent health needs are identified through the RAP assessment, the GARs are taken to the hospital or urgent care clinic and are accompanied by RAP staff and an interpreter, if necessary and if one is available. If health needs are identified but do not require urgent care, the RAP staff liaise with the health coordinator to book the GARs at the Wellness Centre as promptly as possible. In addition, if any of the GARs are identified as having to see a physician upon arrival on the NATs or through the RAP assessment and it is identified through the assessment that it is for sexual health, the RAP staff will refer them immediately to the Ottawa Public Health Sexual Health Clinic and also to the Wellness Centre.

During the GARs stay at the reception centre, they will each have a medical history taken through Help Advocacy for Refugees Program (HARP). Medical students from the University of Ottawa under the supervision of a professor or the Wellness Centre coordinator conduct an interview with each GAR. HARP operates twice per week during the university school year. There are approximately two to three students per HARP day at the reception centre. Interpreters are arranged and provided by the RAP staff at the reception centre. The GARs medical histories are then sent with them to the Wellness Centre for their initial health assessment and thereafter to the GARs' family physicians with whom they become attached.

While the GARs are at the reception centre, the RAP staff work with the health coordinator to ensure that immunization forms are sent to the Wellness Centre and completed as required. As the GARs health appointments occur from the 15<sup>th</sup> day of their arrival onward, follow-up on immunization forms are completed by the CSS staff.

The CSS assessment is conducted 10 working days after the GARs arrival at the reception centre. The RAP staff provide the RAP assessments to the CSS staff so that any information that pertains to both may be transferred. If any health needs are identified through the CSS assessment, the CSS staff arranges health services for the GARs at the Wellness Centre through the health coordinator. If any emergency or urgent health needs are identified through the RAP assessment, the GARs are taken to the hospital or urgent care clinic and are accompanied by CSS staff and an interpreter, if necessary and one is available.

All GARs are seen for an initial health assessment at the Wellness Centre between the third week and three months after arrival in Ontario. The Wellness Centre operates between one day per week and two days per week. The Wellness Centre is located at 219 Argyle St. The Wellness Centre was equipped through one-time funding from the Champlain LHIN. There are two nurse practitioners, two physicians, and a health coordinator who provide the initial health assessment services at the Wellness Centre on a part-time basis and who are employed by SWCHC. The funding for their services is also provided through the LHIN as part of ongoing (core) funding to SWCHC. The GARs also may be provided immunizations at their assessment.

If anything comes to light during the health assessment, the GARs are scheduled and seen for a follow-up appointment. The follow-ups are scheduled with the assistance of the health coordinator and/or the CSS staff. If GARs have high priority health needs the health coordinators work in collaboration with the CSS staff to attach those GARs to family physicians.

Following the refugee health assessment the CSS staff attempt to attach the GARs to family physicians. If the GARs require health services in their first year in Ontario and are not attached to a family physician, the physicians at the Refugee Health Clinic will continue to see them.

Once per month, Ottawa Public Health provided TB screening at the Wellness Centre. GARs may also be referred to Ottawa Public Health for TB screening or immunizations. The Wellness Centre has a strong relationship with Public Health and the health coordinator will arrange appointments for GARs as appropriate. For groups of GARs that have had CIC health protocols, Public Health will send nurses to the Reception House to provide TB screening and immunizations onsite.

In addition to initial health assessments, the Wellness Centre provides a Well Women Clinic each week. Each of the female GARs between the ages of 16 and 60 are seen in the Well Women Clinic but only after they have had their initial health assessment.

## Partners

### *Formal Partners*

Ottawa is distinct among the six Ontario sites relative to its formal health partners as it is one of two sites with a dedicated health clinic, the Wellness Centre. As the Wellness Centre is effectively a site of SWCHC, the Catholic Immigration Centre has a formal relationship with SWCHC for the provision of health services. The GARs are not patients of SWCHC but of the Wellness Centre as the CHC roster for patients is closed therefore they are billed as fee-for-services clients.

### *Informal Partners*

As described earlier, the Wellness Centre was established with one-time funding from the Champlain LHIN and maintained through ongoing funding from the LHIN through SWCHC. It was noted that this funding was obtained in part due to the advocacy of Dr. Kevin Pottie. At the time Dr. Pottie was working at the Bruyere Clinic and was advocating that a clinic for refugee health be established onsite at the Reception House. This informal partnership between Dr. Pottie and the Catholic Immigration Centre resulted in the establishment of the Wellness Centre.

The Ottawa site has a large number of informal partners. These partners range from primary care providers to mental health service providers to specialists to allied health service providers.

Below is a table of the health partners of the Reception House, their roles, and brief descriptions of the services they provide.

Table 8: Ottawa Site Health Service Provider Partners

Organization	Role	Type	Description
<b>Somerset West Community Health Centre</b>	Provide staff/ health service providers and funding for the Wellness Center	Formal	SWCHC provides the ongoing funding, health coordinator, NPs, and physicians that provide health assessments to all GARs and follow-ups to those who require it.
<b>Ottawa Public Health</b>	Provide immunizations, TB screening, and HIV/AIDS education and treatment	Informal	Ottawa Public Health will provide immunizations and TB screening onsite at the Reception House for groups of GARs that arrive for whom the CIC has developed protocols. Ottawa Public Health provides TB screening once per month at the Wellness Centre. GARs are referred to Public Health for immunizations and screening as well as needed. Finally, GARs with HIV/AIDS are referred to the Public Health Sexual Health Clinic.
<b>Pharmacy</b>	Provide prescriptions to GARs and bill IFH	Informal	There is one pharmacy that is in close proximity to the Reception House that is used regularly by RAP and CSS staff. The pharmacy is familiar with IFH and will provide the RAP and CSS staff with information required to receive pre-approval for medications.
<b>Optometrists</b>	Provide optometry services	Informal	There are four optometrists with whom the Reception House has informal partnerships. These optometrists are registered with IFH and will bill their services through IFH. In addition, these optometrists will see the GARs with same day service.

### Challenges

Although the Wellness Centre receives on-going funding to provide health services to GARs, it does not receive funding for interpretation. Interpretation therefore comes from the RAP and CSS budgets. While this is the case at all Ontario sites with the exception of Toronto, it is of note that Ottawa receives the second largest number of GARs, the majority of whom require interpretation for their health services.

The Catholic Immigration Centre reports that many of the GARs arriving at their site require mental health services and that there is no funding to provide such services. The Catholic Immigration Centre had previously received funding for a counsellor to provide mental health services but that funding has been discontinued and GARs are now referred elsewhere for those services. Due to a perceived shortage in mental health services in Ottawa, it can be a challenge to refer GARs to mental health services.

### **Promising Practices**

The Catholic Immigration Centre has a dedicated Wellness Centre that provides initial health assessments and health services to GARs. The Wellness Centre ensures that all GARs receive an initial health assessment within the first three weeks to three months of their arrival in Ontario. In addition, because the Wellness Centre sees only GARs, the staff are familiar with GARs related health issues and cultural competency issues. Further, the Wellness Centre works closely with the RAP and CSS staff ensuring timely responses to health issues and greater continuity of care for GARs.

HARP provides GARs with medical histories. This is reported to facilitate the process of finding family physicians for GARs as family physicians are reported to be more willing to take on GARs with medical histories. HARP provides the medical students with education about refugee health issues and cultural competency as well as working with an interpreter. It also increases the efficiency of the initial medical assessment at the Wellness Centre as it produces health data, in addition to that on the NATs that providers can utilize to deliver health services. Finally, HARP services are free of cost to the Catholic Immigration Centre, with the exception of the provision of interpretation services.

The Catholic Immigration Centre and SWCHC (through the Wellness Centre) also provide health literacy workshops. These workshops are provided to health professionals in the Ottawa area in a “train the trainer” format. The purpose of the workshops is to educate health professionals who might work with GARs about their specific needs and the importance of improving and maintaining GARs health.

## Toronto

### Context

The Toronto RAP and CSS services are contracted through COSTI Immigrant Services (COSTI). The organization has been contracted to provide RAP services since 1998. COSTI was the first RAP serving organization to collaborate on the initial CMP pilot in 2005/2006 with the YMCA of Greater Toronto who delivered the case management support to 70 GAR families/cases. The rollout of the CSS program in 2007-2008 across the province shifted the case management role to COSTI with the YMCA identified as the regional coordinator for all six CSS pilot/program sites. COSTI operates its RAP and CSS services from two locations. The reception centre is located at 100 Lippincott St and the RAP and CSS offices are located at 760 College St. The GARs reside at the reception centre while they are in RAP, which is approximately for 12 days.

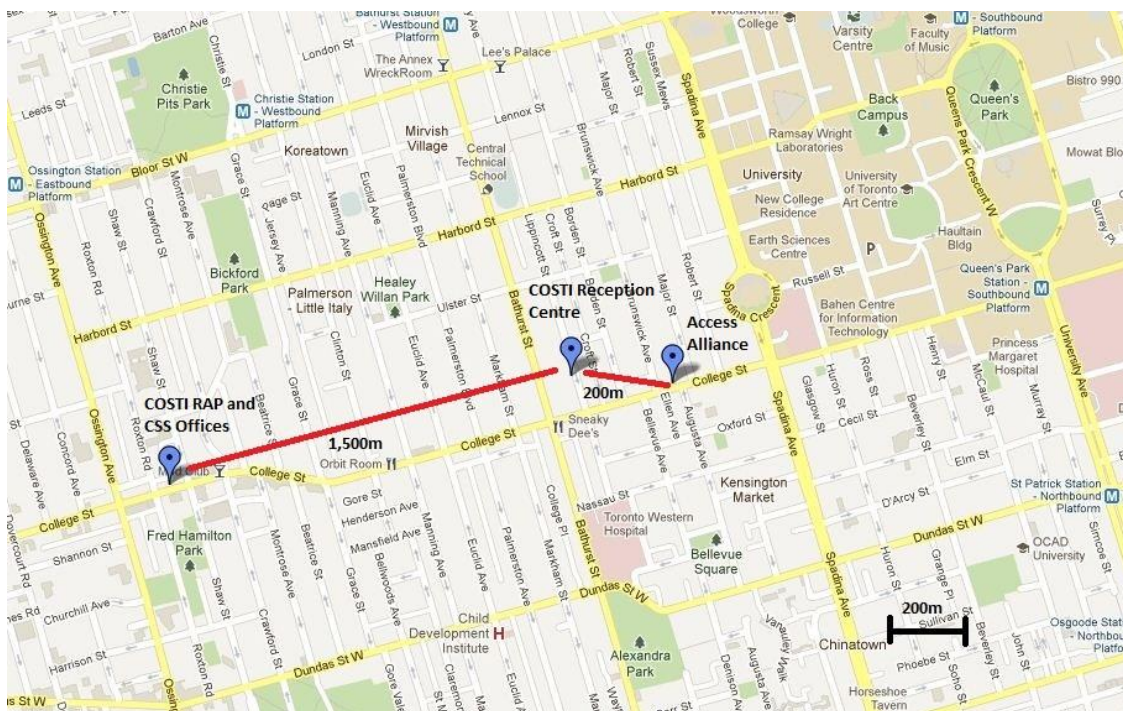


Figure 17: Map of Toronto Site and Health Service Provider Partners

Figure 17 is a map of central Toronto demonstrating the location of the reception centre and the RAP and CSS offices. In addition, Access Alliance Multicultural Health and Community Services (Access Alliance) is shown as it is COSTI's key partner for the provision of health services. As can be seen on the map, Access Alliance is walking distance from the reception centre.

### Site Profile

Toronto receives approximately 1,000 GARs annually. Figure 18 is a chart depicting the monthly arrivals of GARs in 2010. As can be seen in the chart, the arrival of GARs to the community is variable. There appear to be two peaks season occurring in the spring and late fall. The average number of GARs arriving per month, 90, is noted in red in Figure 18.



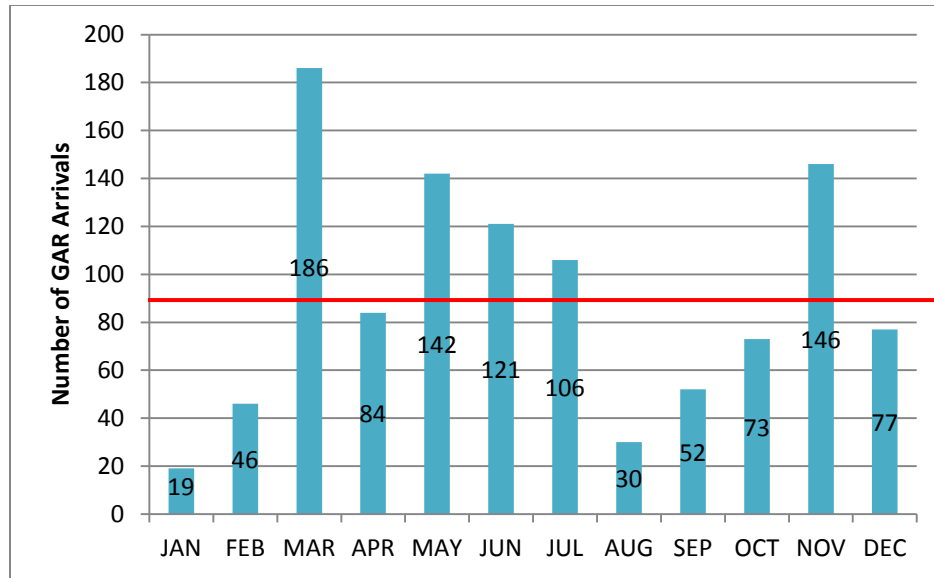


Figure 18: Arrival of GARs to Toronto (2010)

Figure 19 demonstrates the percentage of arrivals by age group as well as the percentage of health needs per age group. As can be seen in the chart, the greatest percentage of GARs that arrived in 2010 was adults 25-59 years old. However, that age group had a relatively lower percentage of health needs than the other age groups, with the senior and children having the highest health needs. This is not surprising as children require immunizations to be registered in schools in Ontario and seniors are well documented as having higher health needs than other age groups.

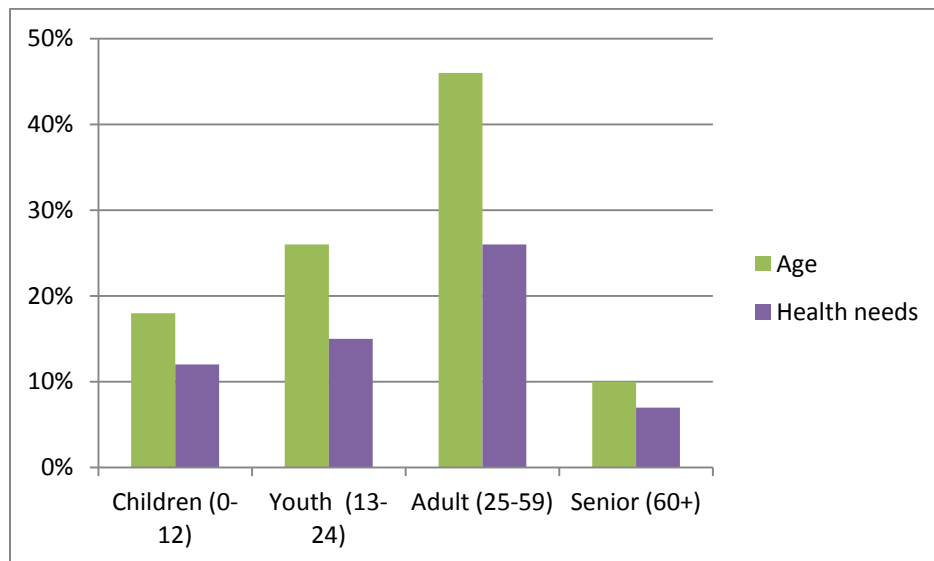


Figure 19: GARs Age and Health Needs (2010)

## Health Services

The Toronto site has a formal partnership with Access Alliance to provide health assessments and follow-up appointments for GARs that require health services. A formal agreement was signed in February 2010, however COSTI and Access Alliance have had a strong informal relationship for the provision of health services to GARs since 2000. (Access Alliance will be described in full in the partners section.) This agreement is for health assessments while GARs are residing at the reception centre, however, if GARs are not attached to a family physician Access Alliance will provide health assessments within the first year of GARs arrival in Ontario and follow-up appointments for two years from the GARs arrival in Ontario. It is of note that Toronto is the only site where there is a health service organization with a mandate to provide health services to GARs. It is also of note that COSTI has the lowest percentage of referrals to health of the five sites (Hamilton is not included) at 12%; the range of percentage of referrals to health for the other four locations is from 42% to 65%. This discrepancy is to be expected as the Toronto site receives the highest number of GARs of any of the six sites with the smallest number of RAP and CSS staff relative to the number of GARs. In addition, the data on the number of referrals may appear lowered in Toronto than it does at other sites. This is due the fact that for those GARs who are provided services through Access Alliance referrals to other health service providers is often coordinated through Access Alliance and therefore may not be logged in the RAP or CSS health referrals. For these reasons, Toronto is an anomaly when comparing the provision of access to health services to GARs.

As with other sites, COSTI also has relationships with other health service delivery partners in addition to its formal partnership with Access Alliance.

## Planning

When the RAP staff receive the NATs for the GARs they are reviewed and orientation activities are planned. If the GARs' NATs contain flagged health needs, RAP staff contact Access Alliance to pre-book appointments for those GARs. The nurse practitioner at Access Alliance then determines whether the GARs should be seen by a nurse practitioner or physician, and books the appointments accordingly. Orientation activities are then planned to account for the flagged health needs and the GARs health appointments.

If any urgent health needs are flagged on the NATs, the RAP staff arrange for those GARs to be taken to an urgent care clinic or the emergency room as needed upon or shortly after arrival. RAP staff and an interpreter, if necessary, accompany the GARs.

The health needs of GARs arriving in Toronto in their first year in Ontario are shown in Figure 20 below.



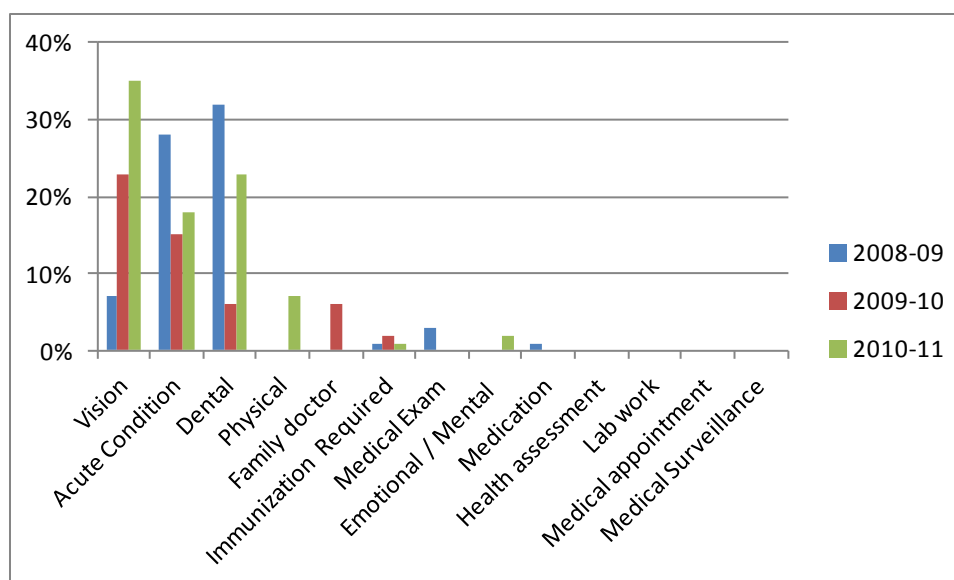


Figure 20: Health Needs of GARs in Their First Year in Ontario

### *Coordination and Provision of Health Services*

When the GARs first arrive, they are greeted by the RAP staff and shown their accommodations. The RAP assessments are completed by the RAP staff within the GARs first 24 hours at the reception centre. If any emergency or urgent health needs are identified through the RAP assessment, the GARs are taken to the hospital or urgent care clinic and are accompanied by RAP staff and an interpreter, if necessary and if one is available. If the GARs present with a non-urgent health need during their time at the reception centre the RAP staff will contact the nurse practitioner at Access Alliance and book an appointment for the GARs to be seen. The nurse practitioner at Access Alliance will triage the GARs and determine which health practitioner they need to see, whether it should be a nurse practitioner or physician. As mentioned in the Planning section, GARs with health needs that were noted on their NATs have had appointments pre-arranged at Access Alliance to be seen during the time that they reside in the reception centre.

The first appointment that the GARs attend at Access Alliance includes a medical history, a physical, and an examination of the health needs identified on the NATs. The appointment is 45 minutes to an hour in duration. At this appointment, immunizations may be given and tests may be undertaken such as TB tests and blood work. An Access Alliance a registered nurse (RN) or registered practical nurse (RPN) provides any immunizations that are required. If additional lab work and/or imaging are required, the RAP staff will take the GARs for the tests and provide interpreters as required. RAP interpreters accompany the GARs to these appointments.

If TB screening was done at the first appointment, the GARs go back to Access Alliance to have the results read by a clinical health provider two or three days after the tests were done. The GARs are seen as walk-in clients, in that they do not need to have an appointment scheduled in advance for the reading.

A second appointment is booked for the GARs one to two weeks following their first appointment. At this second appointment the GARs are seen by a nurse practitioner or physician, and the best effort is made to maintain the same clinical provider for the GARs for all of their appointments. At this second appointment immunizations are provided. The first appointment test results are reviewed and if needed further tests are conducted. Also, any work that could not be completed during the first appointment due to time constraints is completed. Should the medical practitioner(s) feel it is warranted, the GARs are internally referred to allied health professionals such as social workers or dietitians. At this appointment Access Alliance provides for and covers the cost of interpretation. Note: this is the only organization in Ontario at which the cost of interpretation is paid outside of the CSS program.

The third appointment is the final appointment as prescribed by the health protocol that is used by Access Alliance. This appointment includes a full physical, and should it be warranted, the GARs are referred externally for such health services as dental care or vision testing. At this appointment Access Alliance provides for and covers the cost of interpretation.

If there are follow-ups or referrals needed throughout the first three appointments, they are arranged by Access Alliance. If required, Access Alliance will arrange for interpreters to accompany the GARs. After the GARs move from the reception centre to their permanent accommodations, follow-up appointments or referrals are made by Access Alliance directly with the GARs.

Access Alliance has an organizational mandate to serve GARs and therefore will continue to see any unattached GARs for their first two years after arrival in Ontario, or until it can find another primary care provider with whom to attach the GAR. In cases when GARs are referred to Access Alliance after their departure from the reception centre, it is the CSS worker that would arrange the first appointment for the GAR.

When groups of GARs for whom CIC has issued medical protocols arrive at the reception centre, all of these GARs are seen at Access Alliance. For these groups, the RAP staff works with Access Alliance in advance to schedule all of the arriving GARs for medical appointments. The same appointment schedule outlined above for individual GARs is applied to individuals arriving in groups, including all elements of the post-arrival follow-up.

When GARs leave the reception centre, their RAP needs assessments and intake forms are shared with the CSS team. High priority needs are flagged and they become high priority CSS clients. For those clients, CSS staff contact them in their homes and complete a CSS needs assessment. As with other sites, health is considered a priority in the action plan generated for these GARs. CSS staff work with all GARs to attach them to family physicians in the community of their permanent residence, and if possible one who speaks the same language. Those GARs with high priority health needs are prioritized in finding family physicians.

COSTI has a number of other health service delivery providers with whom the RAP and CSS staff work on a regular basis to provide health services to GARs. These informal partners are listed in the Informal Partners section below.

## Partners

### Formal Partners

COSTI has a formal partnership with Access Alliance for the provision of primary care to GARs requiring health services. Access Alliance has a network of health services providers, both medical and allied, that it draws upon for referral of GARs. These include specialists and allied health providers such as dentists and optometrists.

### Informal Partners

The Toronto site has a large number of informal partners. This is due in part to both COSTI and Access Alliance being involved in the provision of health services to GARs. For health services such as dental services or immunizations, COSTI will work directly with health partners such as Toronto Public Health. Similarly, Access Alliance partners with additional health service providers, some of which are the same as COSTI and some which are not.

Table 9: Toronto Site Health Service Provider Partners

Organization	Role	Type	Description
<b>Access Alliance Multicultural Health and Community Services</b>	Provide health assessments and primary and secondary care to GARs	Formal	Access Alliance provides health assessments to GARs as requested by RAP or CSS staff. Those GARs also receive follow-up primary care appointments. Access Alliance will also internally refer clients to its secondary care providers as appropriate. Access Alliance will accept GARs as clients at any time within their first year in Ontario and will provide services until their second year in Ontario after arrival.
<b>Toronto Public Health</b>	Provide immunizations, TB screening, and dental services	Informal	Toronto Public Health (TPH) provides both COSTI and Access Alliance with public health information in regards to GARs when requested. TPH also provides immunizations and TB screening to GARs when requested by COSTI. In this case, the GARs would go to a TPH location to receive these health services. Similarly, if COSTI may refer GARs to TPH for those who qualify.

<b>COSTI Family and Mental Health Services Centre</b>	<b>Provide training to RAP and CSS staff and counselling services to Spanish speaking GARs</b>	<b>Informal</b>	<b>COSTI Family and Mental Health Services Centre provides training on mental health to COSTI RAP and CSS staff. The Centre also acts as a contact for COSTI staff for all crisis or mental health related issues of GARs. Finally, the Centre provides counselling in Spanish to Spanish speaking GARs referred by CSS staff.</b>
<b>Canadian Centre for Victims of Torture (CCVT)</b>	<b>Provide mental health and settlement services to GARs that have been victims of torture</b>	<b>Informal</b>	<b>COSTI will refer GARs to CCVT should their RAP or CSS case managers feel that it is appropriate. CCVT provides services through a multidisciplinary team of psychologists, social workers, and settlement workers to address the needs of GARs who identified as requiring their services.</b>
<b>Centre for Addiction and Mental Health (CAMH)</b>	Provide trauma and mental health counselling, and crisis intervention	Informal	COSTI has a strong partnership with CAMH. RAP and CSS refer GARs as needed for provision of trauma and mental health counselling, crisis intervention, and support groups.
<b>Dentists</b>	Provide dental services to GARs through Toronto Public Health or billed through IFH	Informal	Both COSTI and Access Alliance have informal partnerships with dentists who provide services to GARs. This includes dental services provided through Toronto Public Health (be it at a clinic site or hosted through Access Alliance) as well as dentists that are registered with IFH. RAP, CSS, or Access Alliance staff may refer clients to these dental services as needed.
<b>CNIB</b>	Provide classes in Braille and guide dogs	Informal	COSTI has an informal partnership with CNIB. GARs with vision loss are referred by RAP or CSS staff for Braille and/or guide dogs.
<b>Health equipment providers</b>	Provide health equipment to GARs billed through IFH or OHIP	Informal	There a select number of organizations that are registered with IFH with which Access Alliance and COSTI work to obtain health equipment for GARs. One key informal partner for these services is the local Community Care Access Centre.

## Challenges

Toronto receives the highest number of GARs of any of the sites in Ontario. While it is the largest city among the sites, and therefore is expected to have the highest proportion of GARs arriving, this does present challenges in providing health services to GARs. For example, Access Alliance is limited in its capacity to provide health assessments to all GARs following the protocol for health services that it has developed. The variability month to month in the arrival of GARs causes an additional issue in that there is often variability in the health services that are required by individuals from month to month.

Subjectively, it is reported that approximately 75% of GARs needs are health related, and addressing these needs consumes a large portion of the time of CSS and RAP staff. At the same time, CSS and RAP staff are required to provide services other than health (as per their contractual agreements with the CIC). When the number of GARs arriving increases it can be expected that this raises pressure to deliver all of the contractually obligated services, and as health services are not part of the contractual agreements of either RAP or CSS it can be expected that health services would be difficult to prioritize.

Finally, Toronto has the largest geographic area of the six receiving cities. The result is that GARs may settle into different communities within the Greater Toronto Area. The result is twofold relative to access to and provision of health services to GARs. The first is that when GARs leave the reception centre the travel required of CSS staff is greater to visit GARs in their homes. Second, the network of informal health service delivery partners required to support such a large geographic area has to be extensive and is time consuming to establish and maintain.

## Promising Practices

The formal partnership between COSTI and Access Alliance ensures that GARs have access to primary health services as they are needed and that these are in close proximity to the reception centre. In addition, Access Alliance has a mission to improve health outcomes for the most vulnerable immigrants, refugees, and their communities by facilitating access to services and addressing systemic inequities. Thereby, the GARs arriving at COSTI are within the target populations of Access Alliance. As a result, the staff at Access Alliance are familiar with the health issues of GARs and are trained in cultural competency. Further, Access Alliance developed a health assessment protocol specifically for GARs to ensure that all individuals receive the same and appropriate level of care regardless of which provider they are seen by when they are at the organization.

The proximity of the health service provider to the reception centre was noted as a promising practice. For GARs who have newly arrived in the province it eliminates the need for transportation between the two as GARs travel on foot. Also, should the reception centre staff feel that the GARs are able to return by themselves for follow-up appointments; it frees the RAP and CSS staff to provide other services.

Access Alliance also provides interpreters for the GARs. This relieves the RAP and CSS staff from having to contact a third party to provide these services or provide the services themselves. In addition, it ensures that the GARs receive qualified health interpreters. The interpretation services for GARs for appointments at Access Alliance are provided from the Access Alliance budget which allows COSTI's budget for interpretation to be used for other services.

Finally, although the RAP and CSS offices are at separate locations the staff meet frequently to exchange information and discuss cases. The CSS staff have case consultation meetings weekly. Also, RAP, CSS, and CIC staff meet bimonthly to discuss GARs related issues.



## Windsor

### Context

The RAP and CSS programs in Windsor are provided through the Multicultural Council of Windsor and Essex County (MCC). The MCC was contracted through CIC to provide RAP services since in 2001. The CSS program was added in 2007/2008.

The MCC is located at 245 Janette Avenue in North-west downtown Windsor. The MCC provides all of its GARs related services with the exception of the reception centre from that location. Those services include RAP, CSS, and initial health assessments. The reception centre is located at the Days Inn Windsor. The locations of the reception centre and the MCC are identified on the map provided in Figure 21. Also on the map is the Windsor Essex County Health Unit that is a health service partner of the MCC. GARs reside at the reception centre for approximately 10 days.

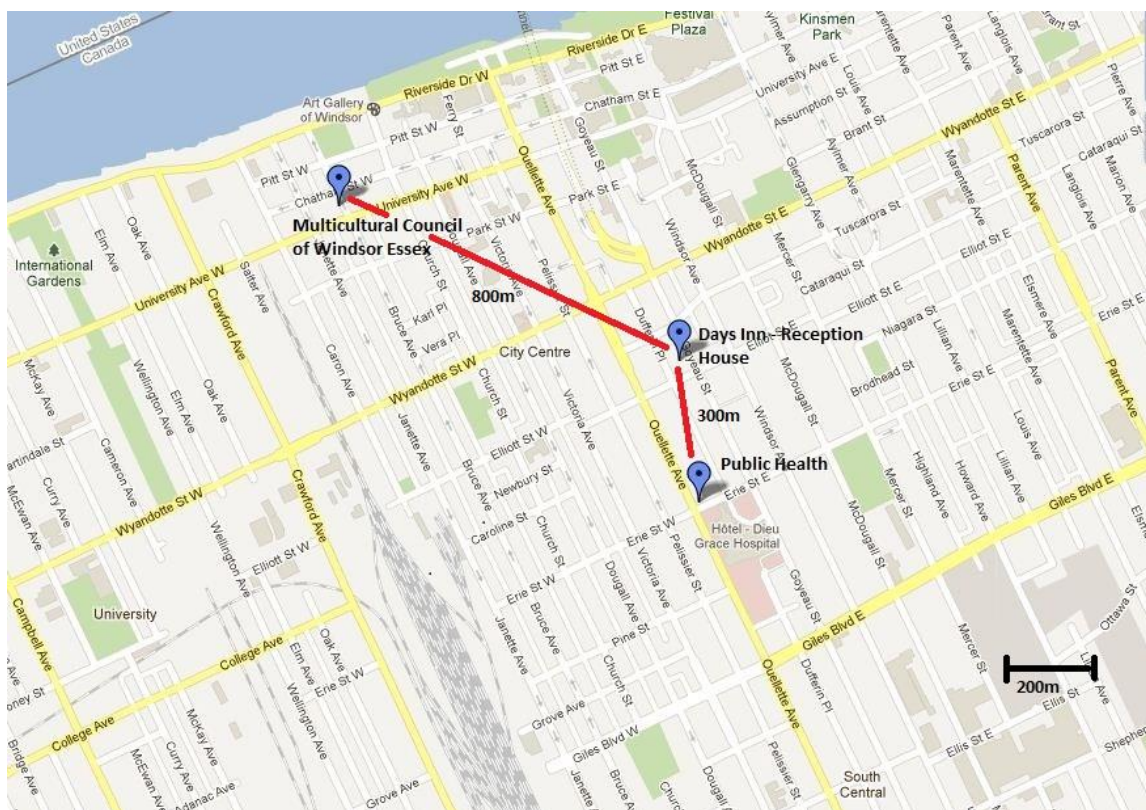


Figure 21: Map of Windsor Site and Health Service Provider Partners

## GARs Profile

Windsor receives approximately 290 GARs per year. In 2010, the site received 299 GARs; the arrivals per month are shown in Figure 22. On average there are 25 GARs who arrive per month in Windsor, the average is denoted by a red line. In the last year, there was a large peak in arrivals in March and a large decrease over the summer.

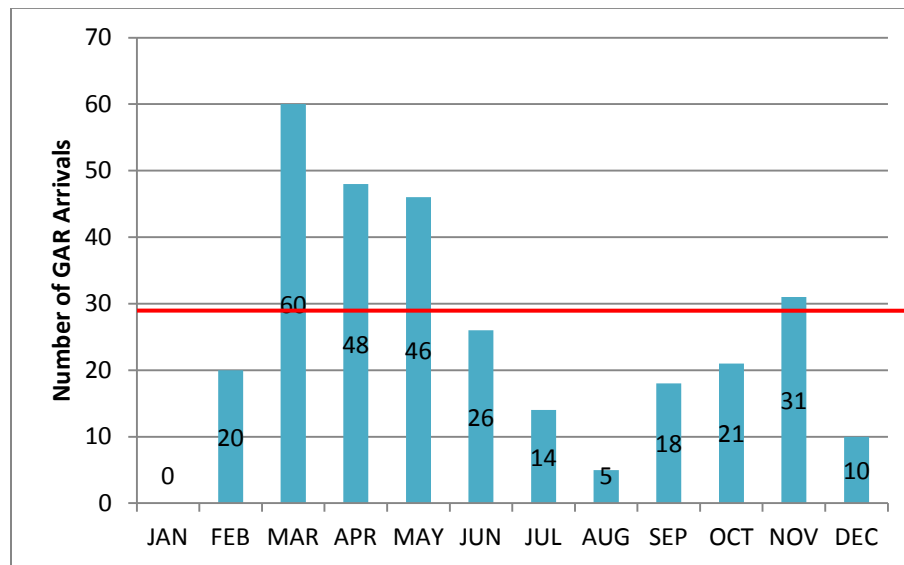


Figure 22: GARs Arrivals to Windsor (2010)

Figure 23 shows the age groups of GARs who arrived in 2010/2011 and the health needs of those GARs per age group. According to 2010/11 data collected by CSS, Windsor has the second highest average number of health needs per client. The GARs arriving in Windsor have an average of three health needs per client. Relative to the other age groups, the senior GARs were the age group with the most health needs. It is of note that health needs were distributed across the age groups proportionately.



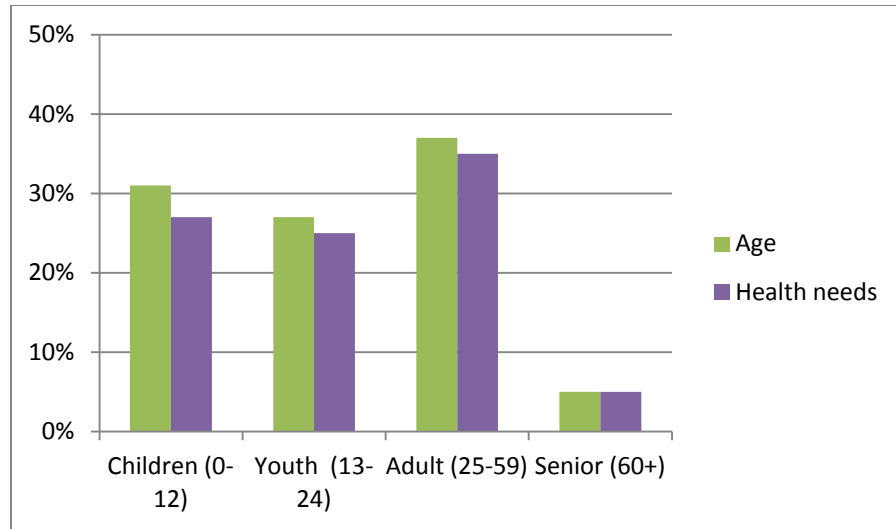


Figure 23: GARs Age and Health Needs (2010)

As noted previously, the health needs of GARs in Windsor rate as the topmost need at 42%. This rating is, however, the second lowest among the other sites. That being said, the rate of health needs is 30% higher than the next need which is community and recreation, followed by settlement information and education and training.

### Health Services

Windsor is in a unique position in providing health services to GARs who arrive at the site. In 2008, the MCC received funding from the MOHLTC for the services of a nurse practitioner and its clinic under the Healthy Communities Fund. Therefore health services are now provided to all GARs onsite at the MCC.

Another difference between the Windsor site and the others is that the RAP and CSS programs have been blended. Although the roles and responsibilities of the RAP and CSS staff remain distinct, there is one person to whom they report and who has decision-making authority relative to the GARs.

Figure 24, below, shows the health needs of GARs in Windsor in their first year in Ontario.

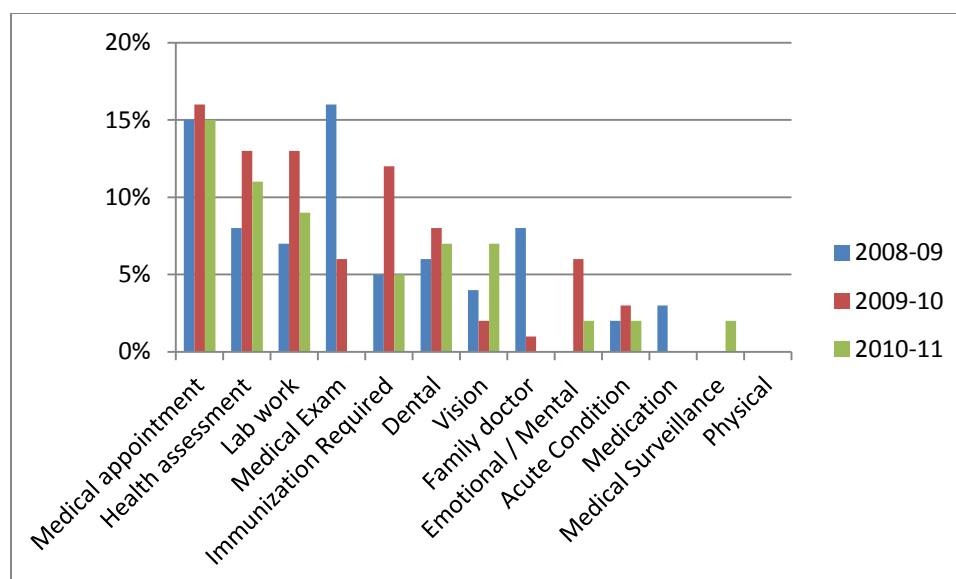


Figure 24: GARs Health Needs in Their First Year in Ontario

### Planning

The NAT is received and reviews by both the RAP and CSS staff and planning for orientation activities is completed collaboratively. The program manager sends the NP the NATs when they arrive and she reviews them. The NP then liaises with the RAP and CSS staff to book the GARs health assessments and language aids or interpreters. If there are flagged health needs on the NAT the RAP and CSS staff and NP confer to find a time for the GARs to be seen by the NP as soon as possible, generally within 2 days. All other GARs are booked for a complete newcomer health assessment and health orientation with the NP within two months of their arrival in Ontario.

### Coordination and Provision of Health Services

The RAP staff meet the GARs within 24 hours of their arrival at the hotel and complete the RAP assessment. Within four days of the RAP assessment, the CSS workers will go to the hotel to introduce themselves. At some point during the GARs time at the reception centre, the CSS staff will carry out the first stage of the CSS assessment. This assessment is continued and updated throughout the first year that the GAR is in Ontario.

Those GARs that were assessed as having high health needs are provided a health assessment by the NP. The complete health assessment and orientation consists of four appointments with the NP. The first one to two appointments of the health assessment are provided while the GARs are staying at the reception centre. The following two appointments occur when the GARs are at their permanent addresses. The first appointment is arranged by RAP while follow-ups are arranged by CSS.

As part of the initial health assessment, the NP also does a brief mental health assessment. If she determines that further assessment is required, she notifies the CSS staff who refer the GARs to a doctoral student of psychology from the University of Windsor Psychology Student and are supervised by Dr. Ben Kuo. Once per week, the students are onsite at the MCC to assess and provide mental health services to GARs. GARs may see the students for ongoing treatment for the duration of their program. This program is active during the duration of the school year, September through May.

During the course of the health assessment and orientation, the NP provides immunizations and TB screening as necessary. For groups of GARs with CIC protocols, immunizations are provided at the Windsor Essex County Health Unit. The NP may also refer individual GARs to the public health unit for immunizations and TB screening should she not have the capacity to provide those services to the GARs. CSS staff coordinate appointments with the public health unit and arrange for interpretation if necessary.

The NP works with the CSS staff to match GARs with family physicians by the third month after their arrival. Should the GARs require health services outside of the health assessment and orientation before being attached to a family physician the NP will provide those services.

## **Partners**

### ***Formal Partners***

Windsor has one of the most formal health service partnerships of any of the six sites as the NP is an employee of the MCC. In addition, the MCC has an informal partnership with the supervising physician for the NP, Dr. Pavan Chand.

### *Informal Partners*

The MCC has a number of informal partners. These partners include psychologists, the Canadian Mental Health Association, the Public Health Unit, and the University of Windsor and Dr. Ben Kuo.

Table 10: Windsor Site Health Service Provider Partners

Organization	Role	Type	Description
<b>Dr. Chand</b>	Supervising physicians for the MCC NP	Formal	Dr. McDermott is the supervising physician for the NP providing on site primary care services to GARs at the MCC.
<b>Network of community partners for immigrant health</b>	Member organization	Informal	MCC participates as a member of a network of community organizations partner to improve immigrant health in Windsor. There are approximately 15 agencies in the network that meet once per month. The network performs activities such as advocacy and providing workshops to immigrants and refugees.
<b>Dr. Ben Kuo</b>	Psychologist, Professor of Psychology	Informal	Provides psychology services to GARs through the MCC. Supervises doctoral psychology students working with GARs during their eight month therapy practicum.
<b>University of Windsor, Psychology Department</b>	Provides doctoral students to provide therapy	Informal	Under the supervision of Dr. Ben Kuo, doctoral students who are doing their therapy practicum see GARs by referral. This is described further in the Promising Practices section.
<b>Dr. Annette Dufresne</b>	Psychologist	Informal	Until March 31, 2011, Dr. Dufresne provided informal support to GARs families through weekly drop-in sessions after they had left the reception centre. These sessions included expression through art and music, talk therapy, and education sessions. This program ended due to lack of funds.
<b>Windsor Essex County Health Unit</b>	Immunizations and TB and dental screening	Informal	Provides immunizations and TB screening to GARs who are sent to the Health Unit by the MCC. Since the MCC began employing a Nurse Practitioner, she provides the GARs with immunizations and TB screening as a component of the health assessment, however, she will send GARs to the public health unit should she not be able to provide immunizations or TB screening in house. The Health Unit also provides dental screening to children who

Organization	Role	Type	Description
			are referred by the MCC. For groups of GARs for which there are CIC health protocols, the GARs are seen at the public health unit for immunizations and TB screening the first day after their arrival.
<b>Pharmacists</b>	Dispense prescriptions to GARs	Informal	There is a pharmacy that is in the area in which GARs tend to reside that provides services regularly to GARs. This includes providing information to GARs in regards to prescriptions and billing IFH.
<b>Lab providers</b>	Laboratory services	Informal	Similar to the pharmacy, there are select lab providers that accept GARs as clients more readily and thus have formed informal partnerships with the MCC.

### Challenges

Procuring OHIP coverage for the GARs during their time at the reception centre is a challenge for the MCC. The OHIP office will not accept the MCC as a temporary address when the GARs apply for OHIP coverage. Therefore, the GARs cannot apply for OHIP coverage until they move into their permanent residences. In Windsor, this is on average 10 days after the GARs arrive in Ontario.

The effect of this delay in OHIP coverage is twofold. As providing assistance to GARs in applying for OHIP coverage is a result outlined in the RAP Schedule 1 of the SPO agreement, the Life Skills RAP staff have to extend services to GARs until they are in their permanent residence. This may involve providing mobile services that is not within the RAP staff responsibilities. Secondly, as the delay can be anywhere from six weeks to two months, during this period GARs are ineligible for services that are covered by OHIP and not IFH. These services include services provide by CCAC such as temporary health equipment and community support services.

There is some difficulty accessing the public health dental program for GARs due to a lack of understanding of the IFH program. The fact that GARs hold both OHIP and IFH insurance jointly for the first year that they are in Ontario has caused some confusion regarding eligibility for and billing of dental services at the Windsor Essex Health Unit.

Finally, there is reported to be a greater language barrier at the Windsor site than at the other five sites in Ontario. It is important for interpreters to be trained, not only in interpretation but health setting specific interpretation as well as the ethics of interpreting personal health information. There is a lack of availability of trained interpreters in Windsor that is attributed to the compound effect of the small size of the city and its distance from a major urban centre with access to a greater number and diversity of interpreters. In addition, it is expensive to import interpreters as Windsor is at some distance from another major urban centre in Ontario.

## Promising Practices

To combat this lack of interpreters, the MCC provides community interpretation services for GARs that is funded by the CIC for the duration of their first year in Ontario. The MCC has developed a social enterprise in training and providing interpreters to service providers in Windsor. To increase the capacity of interpreters in Windsor the MCC has introduced “language aids” in addition to qualified interpreters. Language aids are individuals who have been provided orientation in interpretation but have not yet taken the CILISAT or ILSAT<sup>xv</sup>. Language aids are trained due to a lack of interpreters for a specific language; are often new to the country and visible in the community for which they are interpreting. This can be seen as a conflict or cause individuals' reticence in reporting health problems they are experiencing. While access to a greater number of qualified interpreters would be ideal, the language aids provide a service that is essential to the wellbeing of the GARs.

The MCC has procured project funding from the MOHLTC for a nurse practitioner and onsite clinic to provide health assessments to GARs in their first eight weeks in Ontario. The NP provides health services to all MCC clients as needed, not only GARs. The MCC has received project funding for its nurse practitioner to provide health assessments to GARs during their first year in Ontario. The nurse practitioner has developed an informal protocol for health assessments for GARs that involve four visits. Over the course of the three visits, the nurse practitioner ascertains any health concerns that the GARs may have, provides immunizations and TB screening, and requisitions any lab tests and follow-ups as necessary. The nurse practitioner may also refer to physicians, specialists, or psychology students and psychologists working with CSS staff. At the time of this project, the MCC was able to provide health assessments to all GARs with health issues flagged on their NATs within four weeks of their arrival in Ontario and eight weeks for those without health issues flagged on their NATs.

## Overall Findings

This section provides an overall summary of the general findings of the current state assessment.

### Reception Centres

Of the six sites, four of the sites house GARs onsite at the reception centre as opposed to at a hotel. In all cases, the locations in which GARs are housed are in close proximity to the centre of the cities. As such, GARs have geographic access to a wide range of services, including health services within those cities.

### GARs Profile

Since 2008, 7,478 GARs have arrived in Ontario at the six receiving sites. That is an average of 2,492 GARs per year arriving in Ontario. The number arriving per site is depicted in Figure 25. As can be seen in the chart there has been an increase in the number of GARs arriving at the sites each year with the exception of London.

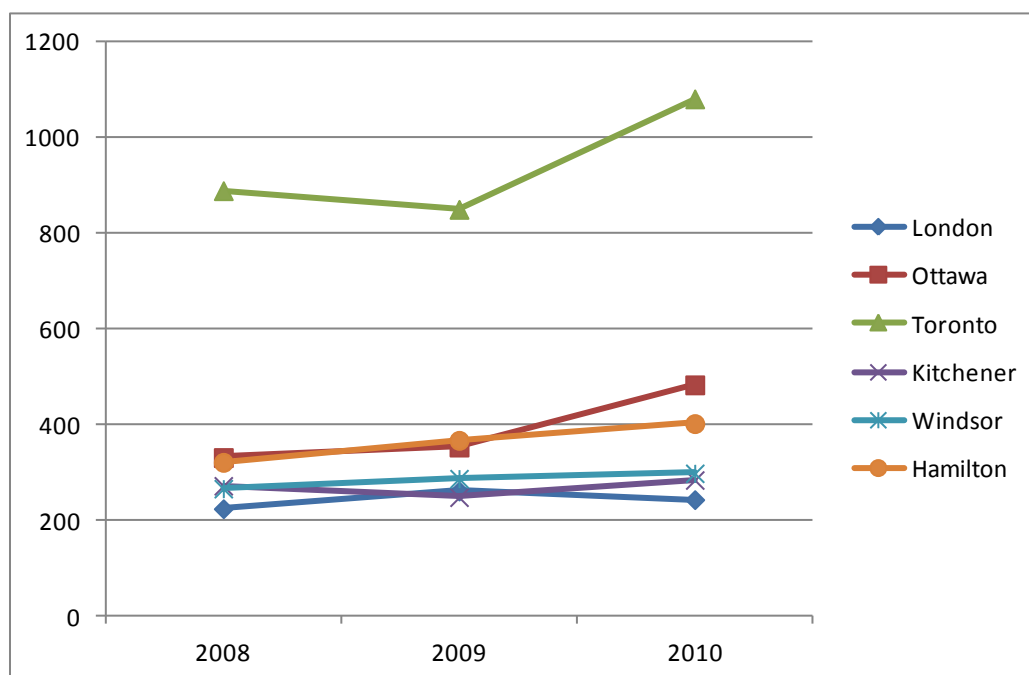


Figure 25: GARs Arrivals in Ontario (2008-2011)

The health needs of GARs in their first year in Ontario across all six sites are shown in Figure 26 below. The needs are listed left to right from greatest average rate of needs to least, for the three years combined.

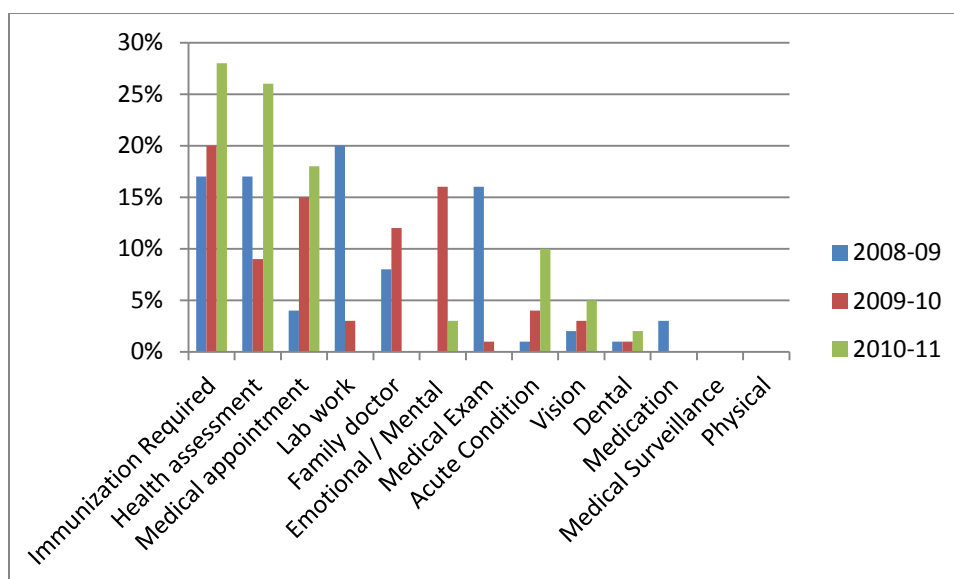


Figure 26: Health Needs of GARs across All Sites in Their First Year in Ontario (2008-2011)

## Health Services

All of the sites in Ontario make health services available to GARs. With the exception of Toronto, all of the sites have developed programs that provide not only health services but health assessment for every new GAR arriving at the site. This is however, not surprising as noted early, due to the large number of GARS arriving in Toronto each year and the contractual obligation of COSTI to provide RAP and CSS services to GARs and not access to health services. Toronto provides health assessments for GARs with health needs that are flagged on the NAT or that are uncovered in the RAP or CSS assessments. Of those sites providing universal health assessments, Hamilton and Kitchener-Waterloo have all GARs participate in a health assessment within the first 15 days after their arrival. London, Ottawa, and Windsor ensure that all GARs attend a health assessment within three months of their arrival.

Three of the six sites (London, Ottawa, and Windsor) have health clinics and/or centres dedicated to the GARs populations. Both London and Windsor have set up health clinics onsite at one of their agency locations. Ottawa's Wellness Centre is located offsite at a local community health centre. Further, Ottawa and Windsor have health services providers who are funded specifically to deliver health services to GARs within their first year in Ontario<sup>1</sup>.

Hamilton, Kitchener-Waterloo, London, and Toronto do not have dedicated funding to deliver health services to GARs. Each has established a partnership with a local health service provider that makes appointments available to GARs. Hamilton and Toronto have both formed partnerships with CHCs that are in close proximity to the reception centres. Kitchener-Waterloo has a partnership with a family

<sup>1</sup> Note: Windsor's MOHLTC funding is for all clients of the MCC, including GARs with high priority health needs.



health team which has established a refugee clinic. London, has established an onsite clinic with services delivered through partnerships with local family physicians and medical residents from the University of Western Ontario residency program. A summary of the health service configuration at each site is provided in Table 11.

Table 11: Summary of Health Service Configuration by Site

<b>Sites</b>	<b>Dedicated Clinic/Centre (as a program of the site)</b>	<b>Partner Clinic/Centre</b>	<b>Which GARs receive health assessments</b>	<b>Timeframe within which health assessments are provided</b>
<b>Hamilton</b>	No	Yes	All	15 days
<b>Kitchener-Waterloo</b>	No	Yes	All	15 days
<b>London</b>	Yes	Yes – onsite	All	2 months
<b>Ottawa</b>	Yes	Yes	As identified as having high health needs by RAP/CSS	3 months
<b>Toronto</b>	No	Yes	As identified by RAP/CSS	1 week following referral from RAP or CSS within the first year in Ontario
<b>Windsor</b>	Yes	Internal	All	3 months

The planning of health services at all six of the sites begins with the review of the NAT that is received by RAP staff. There is a lack of consistency in whether RAP staff, CSS staff, and/or a health coordinator plan the health assessments. Once the GARs have transitioned to their permanent residences however, all six sites utilize CSS staff to plan and coordinate health assessments. Follow-up and other health appointments may be coordinated by CSS staff, health coordinators, and or health partners. It is worth noting that while the GARs are residing at the reception centre any urgent or emergency health services would be coordinated by the RAP staff. Once the GARs have moved to their permanent residences any urgent or emergency health services would be coordinated by the CSS staff. Table 12 shows which roles are planning and coordinating health services at each of the six sites.

Table 12: Summary of Health Planning and Coordination Roles by Site

<b>Sites</b>	<b>Review of NAT completed by:</b>	<b>Coordination of health assessments while GARs are at the reception centre</b>	<b>Coordination of health assessments while GARs are in their permanent residences</b>	<b>Coordination of follow-up / other health appointments</b>
<b>Hamilton</b>	RAP staff	RAP staff	N/A	Health partner and CSS staff
<b>Kitchener-Waterloo</b>	RAP and CSS staff	RAP and CSS staff	N/A	CSS staff
<b>London</b>	RAP and CSS staff	CSS staff and Health Coordinator	CSS staff and Health Coordinator	CSS staff and Health Coordinator
<b>Ottawa</b>	RAP and CSS staff	CSS staff and Health Coordinator	CSS staff	CSS staff and Health Coordinator
<b>Toronto</b>	RAP staff	RAP staff	CSS staff	Health partner and CSS staff
<b>Windsor</b>	RAP and CSS staff	RAP staff	CSS staff	Nurse Practitioner and CSS staff

## Options for Improvement

Based on information collected and consolidated through the interviews and focus group discussions, a number of challenges and promising practices have been identified. This section presents the challenges and opportunities identified in the current state review, as well as the options that have been developed to move towards a standard and consistent health service delivery model across Ontario. The section is organized into two main categories:

- Health Service Delivery Model; and
- Critical Success Factors.

These options were evaluated, assessed and revised at a workshop held on November 28<sup>th</sup> and November 29<sup>th</sup>, 2011. The resulting health service delivery model and priority implementation recommendations are presented in the recommendations section.

### Health Service Delivery Model

At its core, the GARs health service delivery model proposed as an option here will provide access to primary care/health assessment for all GARs. Ideally, the model will be centred around a primary care intake/health assessment and will integrate mental health “screening”, immunizations, TB screening, and referrals to secondary health care providers as required (e.g. optometry, dental). In order to facilitate the delivery of this health service model a series of conditions should be in place. These include: client-centred care; health insurance; partnerships and collaboration; and information and performance management. Figure 27 depicts the health service delivery model for GARs which includes the health assessment in the centre and the connected elements, shown in the red ellipses. Also shown are the critical success factors, in the blue circle, that support the health service delivery model.

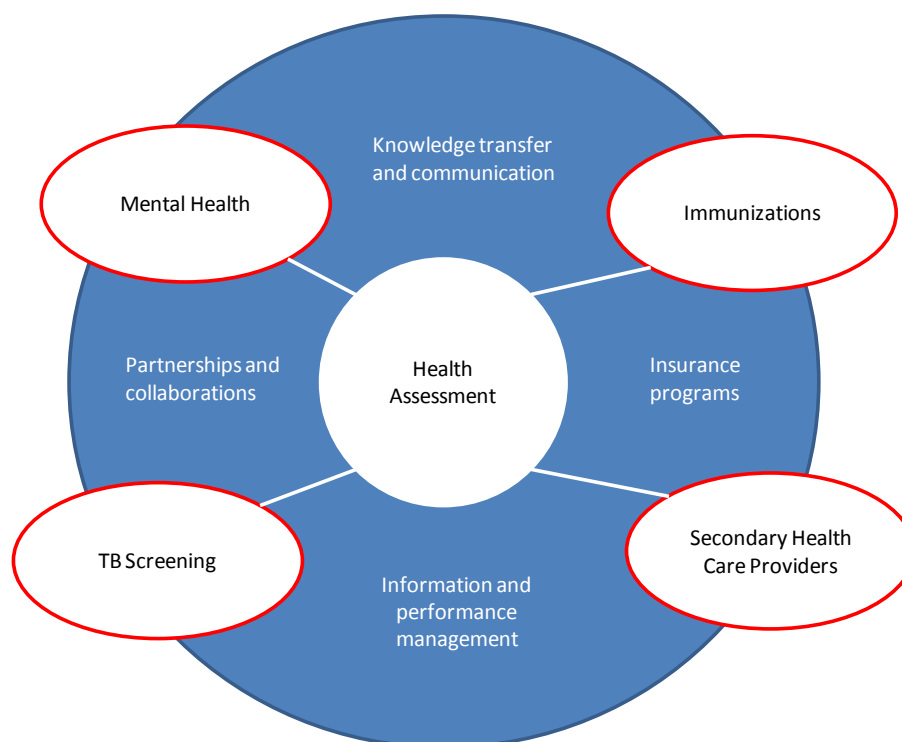


Figure 27: Health Service Delivery Model and Critical Success Factors (for discussion)

#### *A. Primary Care Intake/Health Assessment*

##### *Key Challenge/Opportunity*

There is a lack of policy or program to guide the delivery of health services to GARs. This results in the inconsistent delivery of services and differential access to health services for GARs. This has resulted in and further exacerbates the lack of agreement among service providers as to whether all or some GARs should receive primary care intake/health assessments and how and when, relative to the GARs arrival, these are provided. Finally, with inconsistency in service delivery, the ability to collect or understand province wide information regarding GARs primary health needs in the short or long term is limited.

This study suggests that there is a need for the development of province-wide standards that will provide the sector with a consistent approach to delivering primary health/health assessment services to GARs. The study also shows that there is an opportunity to leverage the promising practices underway across the sites in the development of a standard model and assessment process.

##### *Options for Consideration*

1. Develop provincial service delivery targets/standards for a health service delivery model and health assessment process that can be tracked for continuous quality improvement
  - a. Integrate data requirements related to targets into IMS/reporting system
2. Each site should develop a local response that that is aligned with the provincial standards and targets while still responsive and reflective of its unique community profile and needs

3. Carry out a primary care intake/health assessment for all GARs while they are at the reception centre
4. Deliver primary care onsite or at a nearby location (to avoid inefficiency)
5. Develop a collaborative and interdisciplinary primary care model
  - a. Use NPs to coordinate/deliver primary care services
  - b. Leverage medical residents to deliver primary care
6. Formalize partnerships with local resources such as hospitals, community health centres and public health
7. Enhance health education activities/orientation for GARs during the first year in Ontario
8. Each site should independently and where possible, collectively, pursue funding and advocate with the MOH/LHIN to fund primary care services for GARs

### Primary Impact

The development of a standard primary care model for GARs in Ontario will:

- Ensure GARs, regardless of where in Ontario they are resettling, have equal access to primary care services;
- Support settlement service providers and community partners to deliver consistent primary care services to GARs;
- Facilitate enhanced information sharing and learning among the providers; and
- Support improved planning, information management and evaluation of services to GARs.

## B. Mental Health

### Key Challenge/Opportunity

The lack of mental health services to meet needs in Ontario has been well documented<sup>xvi</sup>. The lack of mental health services is even more pronounced for this population and exacerbated by the lack of expertise among providers in refugee mental health as well as the use of traditional medical/Western models of care where non-traditional services may be more appropriate.

As with health, there is a lack of policy or program to guide the delivery of mental health services to GARs. This results in the inconsistent development and delivery of mental health services (e.g. screening, service delivery, referrals) among the sites and differential access to mental health services for GARs across Ontario. While some sites have very little in place to formally address GARs mental health needs, others have integrated mental health into the overall health service delivery model. All of the sites are struggling to develop a solution to address the long term mental health needs of GARs. This is particularly important as mental health needs are reported as often presenting in GARs six months after they arrived in Ontario.

The findings from this and previous studies<sup>xvii</sup> suggest the need for the development of province-wide standards that will provide the sector with a consistent approach to assessing mental health needs and delivering mental health services to GARs. This study also shows that there is an opportunity to leverage the promising practices underway across the sites in the development of a standard model and

assessment process. For example, sites have established partnerships programs with community based mental health services providers, universities, and private practitioners to support GARs access to mental health services. These partnerships have also facilitated reciprocal learning whereby CSS and RAP providers enhance their mental health knowledge while community and academic partners enhance their knowledge of GARs mental health.

### Options for Consideration

1. Recognize that mental health is a well-documented component of health
  - a. Include mental health within GARs health policy
  - b. Include mental health as a component of any health service delivery model designed for GARs
2. Evaluate the MOSAIC pilot and determine if and/or how mental health services should be rolled out across the GARs sites
3. Establish performance indicators and measures
  - a. Establish common targets for mental health service delivery
  - b. Work with community partners to develop outcome measures that can be used for continuous quality improvement
  - c. Integrate data/information related to the targets and outcomes into the IMS/reporting system
4. Each site should develop a mental health response that is aligned with service delivery standards and targets but which is responsive to unique community needs
  - a. Draw upon existing promising practices to develop local mental health services for GARs
  - b. Leverage experts and partner with experts in the community to deliver mental health services
5. Include a mental health assessment in the health service delivery model/primary care/health assessment  
Train CSS and RAP staff about mental health. Note: CIC has funded a pilot that is currently underway with CAMH to develop e-learning modules on refugee mental health for both the settlement sector and health professionals. It is expected to rollout in early 2012-13
6. Enhance orientation to and education about mental health for GARs

### Primary Impact

The development of a standard mental health service delivery model will:

- Ensure GARs across Ontario have access to mental health assessment and services regardless of where in the province they are resettling;
- Support settlement service providers and community partners to deliver consistent mental health services to GARs;
- Facilitate enhanced information sharing and learning and knowledge and skill development among the diverse service providers working together to address GARs mental health needs; and

- Support improved planning, information management, evaluation and quality improvement of services to GARs.

### C. Immunizations

#### Key Challenge/Opportunity

For children attending school in Ontario, a written immunization record or proof of immunization is required, by law, for diphtheria, tetanus, polio, measles, mumps and rubella unless there is a valid written exemption. Immunizations to protect against most of these diseases are provided for free by Ontario's public health units. Among the GARs sites, immunizations are carried out inconsistently, which may impact the GARs ability to access or stay in school. Further, the public health units in each of the cities appear to have a different understanding of what their involvement in immunizations should be. Some of this confusion arose with CIC's development of Health Management protocols (e.g. for the Karen and Bhutanese communities), where there was a perception that public health units, which come under the purview of the MOHLTC were asked to take direction from a federal body. Despite this confusion and the inconsistent approach to service delivery, there are examples of practices undertaken by sites that effectively support GARs to access the immunizations required by Ontario law or as suggested by evidence-based guidelines.

#### Options for Consideration

1. Define the role and responsibility of CIC, Public Health Ontario, and public health units vis a vis immunizations
2. Recognize and integrate immunizations as a component of the GARs health service delivery model
  - a. Initiate immunizations while GARS are on site at the reception centres
  - b. Include immunizations as a part of the primary care intake/health assessment
3. Establish performance indicators and measures to support continuous quality improvement
  - a. Identify immunization related targets/standards
  - b. Identify outcome measures
  - c. Integrate data related to targets and outcomes into IMS/reporting system
4. Leverage local resources to meet immunization targets and outcomes
  - a. Public health units
    - i. Send all GARs to public health for immunizations
    - ii. Use public health to provide reconciliation of GARs immunization records with the Ontario immunization schedule
  - b. Health providers

#### Primary Impact

Improving how immunizations are delivered to GARs will:

- Ensure that a) GAR children across Ontario have immediate access to the school system, and b) will not be removed from the school system;

- Support settlement service providers and public health units to better understand their role in the delivery of immunizations to GARs; and
- Support improved planning, information management, evaluation, and quality improvement of services to GARs.

#### D. TB Screening

##### Key Challenge/Opportunity

As with immunizations, TB screening is carried out inconsistently across the six sites in Ontario, and public health units in each of the cities have a different understanding of what their involvement should be. Again, some of this confusion can be attributed to CIC's development of Health Management protocols (e.g. for the Karen and Bhutanese communities), where there was a perception that public health units, which come under the purview of the MOHLTC, were being asked to take direction from a federal body. Despite this confusion and the inconsistent approach to service delivery, there are examples of practices undertaken by sites that effectively support TB screening. These include:

- TB screening in accordance with Ontario public health protocols while GARs are at the reception centre Integrating TB screening into the initial health intake
- TB screening in conjunction with the medical history, other tests, or immunizations
- Collaborative approaches (e.g. with public health units and universities)
- Cost efficient options (e.g. medical students)

##### Options for Consideration

1. Define the role and responsibility of CIC, Public Health Ontario and public health units vis a vis TB screening
2. Recognize and integrate TB screening as a component of the GARs health service delivery model
  - a. Carry out TB screening while GARS are on site at the RC
  - b. Include TB screening a part of the primary care intake/health assessment
  - c. Undertake TB screening in conjunction with health history/other test /immunizations
3. Establish performance indicators and measures to support continuous quality improvement
  - a. Identify TB screening targets/standards
  - b. Identify outcome measures
  - c. Integrate data related to targets and outcomes into IMS/reporting system
4. Leverage local resources to meet TB screening targets and outcomes
  - a. Public health units
  - b. Primary care providers
  - c. Universities (e.g. to access medical students and students of other health faculties)

##### Primary Impact

Improving how immunizations are delivered to GARs will:

- Enhance the public health protection and safety of GARs and community members;



- Support settlement service providers and public health units to better understand their role in the delivery of TB screening for GARs; and
- Support improved planning, information management, evaluation and quality improvement of services to GARs.

### **E. Other Health Services**

It is of note that access to specialists was not reported to be a barrier for GARs and therefore specialists are not included in this discussion.

### **Key Challenge/Opportunity**

Currently, the six sites are not able to facilitate GARs access to the range of health services that are often required, including vision and dental care. At the same time, sites have implemented promising practices that should be leveraged. These include:

- Strong network development of allied health service providers in optometry, mental health, diabetes/chronic disease management, and dental services;
- Leveraging universities to provide residents that can deliver health services to GARs;
- Providing training sessions to settlement staff and GARs regarding broader health care issues such as oral health, vision care, etc.; and
- Holding quarterly networking/case management sessions with all staff that are engaged in health service delivery to GARs to strengthen relationships and to effectively coordinate services.

### **Options for Consideration**

1. Carry out regular needs based planning to identify priority health needs identified by GARs
2. Develop and nurture a strong network of allied providers that are practicing in close proximity or that will delivery services in the community (at the reception centres and/or GARS health service delivery sites)
  - a. Hold regular networking sessions
  - b. Support providers to register with IFH
3. Develop collaborative responses to priority health needs with service delivery partners

### **Primary Impact**

Improving GARs access to the broader health services they need will enhance the capacity of GARs to achieve positive settlement and integration outcomes. For example, improved vision care will support learning outcomes for English/French language learners.

## **Critical Success Factors**

### **GARs Centred Care**

This study's findings indicate that there are a series of factors, which while they are not absolute requirements for the implementation of a health service model, are factors that leverage best practices

and/or or address key challenges for service delivery and sustainability. This section presents the factors that have been identified as promoting accessible and appropriate health services for GARs.

## *F. Global Health Expertise*

### *Key Challenge/Opportunity*

While not a requirement for a standard health service delivery model for GARs, this study shows that global health expertise may result in better quality services, improved health outcomes and a better client experience. Global health expertise brings an understanding of the main diseases and health conditions prioritized by global health initiatives, including respiratory diseases, maternal health, HIV/AIDS, malaria, nutrition and micronutrient deficiency, diarrhoeal diseases, and increasingly chronic diseases such as diabetes. There is an opportunity for sites to leverage, build upon, and integrate global health expertise in their service delivery models.

### *Options for Consideration*

1. Develop a program of research and disseminate knowledge regarding refugee health
  - a. Present at conferences such as Metropolis and the Refugee Health Conference
  - b. Actively participate in development of the Refugee Health Conference
  - c. Publish and distribute health profiles for refugee groups
2. Invest in developing expertise in global health
  - a. Promote staff professional development
  - b. Build academic affiliations
3. Provide global health training for all staff involved in health service delivery when planning for the arrival of new GARs groups and/or populations
4. Identify experts in global health at local universities and among SPOs and engage experts to:
  - a. Participate in health service delivery
  - b. Undertake global health education, research
  - c. Support advocacy with policy makers and funding
  - d. Network with other global health experts to build a strong network of GARs service providers
5. Sponsor knowledge transfer activities such as networking sessions and workshops with health service delivery partners

## *G. Cultural Competence*

### *Key Challenge/Opportunity*

As with global health expertise, there is also a lack of cultural competence among both health service providers. Culturally competent services provide care to clients with diverse values, beliefs, and behaviours and are tailored to meet their social, cultural, and linguistic needs. Cultural competence requires an understanding of the communities being served as well as the cultural influences on individual health beliefs and behaviours. Culturally competent providers devise strategies to identify and address cultural barriers to accessing health which impacts GARs access to appropriate health services and the quality of service delivery. Cultural competence is important because it can reduce disparities in

health services and increases detection of culture specific diseases, and reduce inequitable access to primary care. Further, there is often an assumption made about settlement workers that, because they work with immigrants and refugees, they are culturally competent. The findings of this study suggest that this assumption needs to be challenged.

#### Options for Consideration

1. Develop standards regarding cultural competence, including definitions, and personal, professional, and organizational assessment tools
2. Develop and carry out a training program in cultural competency for the interdisciplinary health service team, including RAP and CSS staff and all health service delivery partners
  - a. Carry out ongoing educational/networking activities to promote continuous learning
3. Enhance opportunities for health and settlement students to develop cultural competence within the GARs health service delivery model
4. Increase collaboration with universities and strategic community organizations to gain access to experts in cultural competence
5. Carry out awareness raising activities in the community to promote sensitivity and awareness regarding GARs issues in the broader community

#### H. Interpretation

##### Key Challenge/Opportunity

Studies have shown that refugees who have limited English and/or French language proficiency (LEP/LFP) are among the most vulnerable groups of people living in Ontario, experiencing high levels of unemployment and poor health and housing conditions<sup>xviii</sup>. One of the main challenges experienced by newcomers as they navigate and attempt to access the human services required to address these issues is language barriers. When services are not linguistically appropriate or accessible, newcomers are not able to access the services they need in a timely manner and often, not at all. Conversely, one of the main challenges that service providers experience in the delivery of services to newcomers is an inability to communicate, and therefore the quality of services delivered is significantly impacted. This study confirms that, in addition to a lack of funding for interpretation, there is a lack of access to qualified (e.g. trained and tested interpreters) interpretation, particularly in new/emerging refugee communities and this is further exacerbated in small communities. The study also confirms that in the absence of qualified interpreters, GARs and service providers both rely upon family members and community members to fill the gaps. It also shows that service providers have limited education and training on when and how to use interpreters effectively.

At the same time, this study has uncovered promising practices. First, IFH covers the cost of up to two hours of interpretation for the GARs initial health assessment, and IFH staff is keen to have GARs health service providers use this resource. Protocols regarding cost sharing of interpretation between settlement and health service providers are available for the sites to draw upon. Finally, there are innovative approaches that sites are using to increase their access to interpreters for new and emerging GARs communities.

### Option Options for Consideration

1. Articulate and implement policy and standards regarding interpretation
  - a. Train all sites to apply interpretation standards to service delivery
2. Advocate with the MOHTLC to provide interpretation for health service delivery
3. Educate health service delivery partners as to how to work effectively with interpreters and when they should be used
4. Inform health service delivery partners use IFH to cover interpretation costs related to initial health assessment
5. Include interpretation cost sharing agreements as part of the services partnership agreements with health service delivery partners

## Health Insurance

This section describes options that can improve the government provided insurance programs that are available to GARs.

### *I. Ontario Health Insurance Plan (OHIP)*

#### Key Challenge/Opportunity

This study found that there is inconsistent practice among local OHIP offices regarding temporary addresses. Four of the six sites report that their local OHIP office accepts the reception centre as the temporary address for GARs and issues OHIP immediately on this basis. Two of the sites, however, are not able to secure OHIP for the GARs until they transition from the reception centre to permanent accommodation, thereby delaying access to OHIP and coverage for critical health services, for example assisted services and devices provided by community care access centres.

### Option Options for Consideration

1. Advocate that the MOHLTC to allow reception centres to be exceptions to the OHIP temporary address policy
2. Form strong local relationships with local OHIP offices to speed the acceptance of OHIP applications

### *J. Interim Federal Health Program (IFH)*

#### Key Challenge/Opportunity

With the shift to a new provider in January, the IFH is in transition. This study identified the need for enhanced awareness raising, education, and training to ensure that health service providers: a) register with IFH; b) understand the services covered by IFH (i.e. interpretation); and c) use the IFH system properly. Provider buy-in/registration, however, may be a challenge as the current IFH provider needs to overcome historical issues in customer services and reimbursement. In addition, with the switch to a new provider policy changes were implemented to align IFH with OHIP and as a result of the new claim schedule, certain services are no longer eligible for coverage under IFH (e.g. community care access centre). Further, new operational guidelines do not allow RAP and CSS staff to register as service providers, and therefore they no longer have access to client records. While this previously limited RAP

and CSS staff's ability to follow-up on claims and their capacity to advocate for clients and/or their health service delivery partners IFH and Medavie have recently changed their policy to allow for this. Settlement SPOs may now call Medavie or fax a prior approval form identifying themselves as Special Authorization Representative and thereafter receive information in regards to approval requests.

Sites are using different strategies to deal with the transition to a new provider. For example, some sites engage their regional CIC office to troubleshoot problems with IFH and at other sites RAP/CSS staff is delivering providing information sessions regarding the IFH billing process for health service delivery partners.

### Options for Consideration

1. Enhance awareness raising and training and education activities to promote uptake among health service providers (i.e. Medavie Blue Cross could be contracted to provide these activities)
2. Evaluate the impact of the policy change to align with OHIP (e.g. impact of change on the timeliness of coverage on things such as wheelchairs)
3. Ensure standards for payment and customer service are outlined in the contract with Medavie Blue Cross
4. Monitor the performance of Medavie against standards

### Partnerships and Collaboration

This section presents options for enhancing a collaborative approach to health service delivery.

#### *K. CSS/RAP Collaboration and Integration*

##### Key Challenge/Opportunity

This study suggests that integration of CSS and RAP results in more efficient and/or effective health service delivery. Integration facilitates proactive identification and action on health issues; enhances communication with health service delivery partners; makes efficient use of limited resources; reduces the need for redundant activities (i.e. one intake process) and streamlines the transition for clients from one provider (RAP) to another (CSS). Currently, the level of integration between CSS and RAP varies from site to site from highly integrated (e.g. one intake process) to more informal collaboration (e.g. sharing office space to facilitate communication).

### Options for Consideration

1. Clearly define the roles and responsibilities of RAP and CSS in the health service delivery model
2. Establish health service performance targets and outcomes for both the RAP and CSS program
3. Integrate the targets and outcomes into the RAP and CSS reporting system
4. Integrate data regarding targets and outcomes into the existing CSS IMS
5. Develop and implement mechanisms for regular and formal communication and/or case management between CSS and RAP (e.g. shared office space, regular planning meetings)
6. Centralize the approach to the management and oversight of health services
7. Assign responsibility/oversight/management for health service planning, delivery, and outcomes to one person

## ***L. Partnerships***

### **Key Challenge/Opportunity**

Study participants agreed that range of health needs experienced by GARs cannot be met by one provider alone. Rather, identifying and leveraging local resources for the health service delivery model can help to meet those needs. Currently, sites are leveraging their local resources in a variety of ways:

- To provide education and information regarding global health, mental health, cultural competence, etc.
- To deliver services such as mental health and optometry services
- To build their roster of health providers through community awareness raising regarding GARs health
- To carry out research regarding GARs health
- To support advocacy efforts with funders and policy makers in order to secure additional resources for health services
- To participate in program planning and continuous quality improvement activities such as case management

In particular, each of the sites is located in close proximity to a university/teaching hospital. Sites are capitalizing on this by engaging faculty and students/residents in the health service delivery model; by accessing clinical space and by leveraging research generated by experts to advocate for GARs specific health resources.

### **Options for Consideration**

1. Facilitate the development of formal relationships with key partners such as universities
2. Draw upon the promising practices already underway in the province to strengthen the interdisciplinary nature of health service delivery at each site
3. Hold quarterly networking meetings with all health service delivery partners to ensure good communication and collaboration
4. Develop formal mechanisms to share information regularly and routinely with health service delivery partners
5. Develop formal partnership agreements with all key health service delivery partners
6. Develop and nurture informal partnerships with a broad range of other health and social service providers

### **Performance and Information Management**

This section describes options related to improving the collection and use of GARs health data and information. Figure 28 depicts the cyclical nature of needs based planning and the importance of information collection in the process. Information is used to identify GARs needs, determine partnership and programmatic requirements, and monitor the delivery of services in meeting needs and improving conditions.

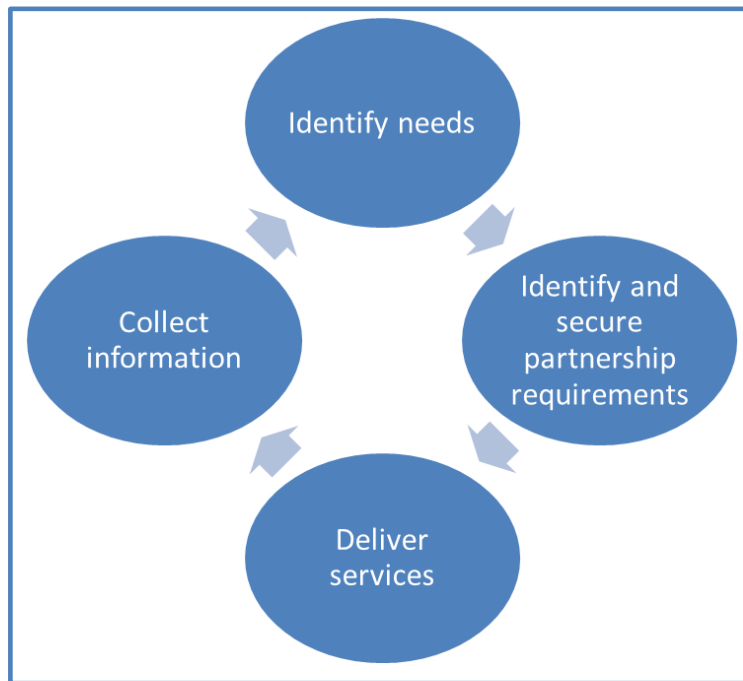


Figure 28: Needs-Based Planning Cycle

### *M. Planning and Evaluation*

#### Key Challenge/Opportunity

The CSS program has a robust information management system that should be leveraged for program planning and continuous quality improvement.

#### Options for Consideration

1. Review the CSS information management system to ensure data/information for health service targets and outcomes is being collected, analyzed, and reported
2. Integrate the RAP and CSS reporting and information management systems Establish and embed information collection and reporting requirements into SPO contribution agreements
3. Use CSS and RAP data and information to plan health services
4. Develop and implement an regular approach to planning (e.g. needs based planning process, theory of change, logic model)
5. Develop planning skills and capacity among RAP and CSS staff
6. Involve all health service delivery partners in the planning process
7. Use academic partnerships to carry out research and/or evaluation (e.g. chart audits) in order to produce the data/information required for planning purposes



## N. Personal Health Information

### Key Challenge/Opportunity

There is a lack of understanding on the part of both settlement and health service providers regarding Canada's and Ontario's legislation regarding personal health information. As a consequence, settlement providers are actually over concerned about sharing personal health information.

### Options for Consideration

1. Compliance with PHIPA should be included as part of the contribution agreement with settlement SPOs
2. Settlement staff should be provided with training and education regarding PHIPA
3. Health service delivery partnership agreements should reference to compliance with PHIPA

## O. Health History

### Key Challenge/Opportunity

There is no consistent approach to how health history is collected across the six sites. This study found that without a medical history it is sometimes challenging to refer GARs to family physicians, who do not want to take on clients without this. At the same time, it appears that there is a lack of understanding regarding the overseas Initial Medical Exam (IME). It is assumed that the IME provides useful medical information to health care providers. However, the IME is often dated and less useful than health providers expect and cannot be relied upon to replace the need for health history in Ontario.

### Options for Consideration

1. Evaluate the pilot project underway to share the IME and determine whether to expand the project to other sites
2. Leverage local resources (e.g. medical residents) to carry out a medical history that can be shared with the GARs' family physicians

## Summary of Options for Improvement

Health Service Delivery Model	Options	Responsible Party	
		CIC	Sites
Primary Care Intake/Health Assessment	Develop provincial service delivery targets/standards for a health service delivery model and health assessment process that can be tracked for continuous quality improvement <ul style="list-style-type: none"><li>• Integrate data requirements related to targets into IMS/reporting system</li></ul>	X	
	Develop a local response that that is aligned with the provincial standards and targets while still responsive and reflective of its unique community profile and		X

Health Service Delivery Model	Options	Responsible Party	
		CIC	Sites
	needs		
	Carry out a primary care intake/health assessment for all GARs while they are at the reception centre		X
	Deliver primary care onsite or at a nearby location (to avoid inefficiency)		X
	Develop a collaborative and interdisciplinary primary care model <ul style="list-style-type: none"> <li>• Use NPs to coordinate/deliver primary care services</li> <li>• Leverage medical residents to deliver primary care</li> <li>• Formalize partnerships with local resources such as hospitals, community health centres and public health</li> </ul>		X
	Enhance health education activities/orientation for GARs during the first year in Ontario		X
	Pursue funding and advocate with the MOH/LHIN to fund primary care services for GARs	X	X
<b>Mental Health</b>	Recognize that mental health is a well-documented component of health <ul style="list-style-type: none"> <li>• Include mental health within GARs health policy</li> <li>• Include mental health as a component of any health service delivery model designed for GARs</li> </ul>	X	
	Evaluate the MOSAIC pilot and determine if and/or how mental health services should be rolled out across the GARs sites	X	
	Establish performance indicators and measures <ul style="list-style-type: none"> <li>• Establish common targets for mental health service delivery</li> <li>• Work with community partners to develop outcome measures that can be used for continuous quality improvement</li> <li>• Integrate data/information related to the targets and outcomes into the IMS/reporting system</li> </ul>	X	
	Develop a mental health response that is aligned with service delivery standards and targets but which is responsive to unique community needs <ul style="list-style-type: none"> <li>• Draw upon existing promising practices to develop local mental health services for GARs</li> <li>• Leverage experts and partner with experts in the community to deliver mental health services</li> </ul>		X
	Include a mental health assessment in the health service delivery model/primary care/health		X

Health Service Delivery Model	Options	Responsible Party	
		CIC	Sites
	assessment		
	Train CSS and RAP staff about mental health	X	X
	Enhance orientation to and education about mental health for GARs		X
<b>Immunizations</b>	Define the role and responsibility of CIC, Public Health Ontario, and public health units vis a vis immunizations	X	
	Recognize and integrate immunizations as a component of the GARs health service delivery model Initiate immunizations while GARS are on site at the reception centres Include immunizations as a part of the primary care intake/health assessment		X
	Establish performance indicators and measures to support continuous quality improvement Identify immunization related targets/standards Identify outcome measures Integrate data related to targets and outcomes into IMS/reporting system	X	
	Leverage local resources to meet immunization targets and outcomes Public health units Send all GARs to public health for immunizations Use public health to provide reconciliation of GARs immunization records with the Ontario immunization schedule Health providers		X
<b>T. B. Screening</b>	Define the role and responsibility of CIC, Public Health Ontario and public health units vis a vis TB screening	X	
	Recognize and integrate TB screening as a component of the GARs health service delivery model <ul style="list-style-type: none"> <li>Carry out TB screening while GARS are on site at the RC</li> <li>Include TB screening a part of the primary care intake/health assessment</li> <li>Undertake TB screening in conjunction with health history /other test / immunizations</li> </ul>		X
	Establish performance indicators and measures to support continuous quality improvement <ul style="list-style-type: none"> <li>Identify TB screening targets/standards</li> <li>Identify outcome measures</li> <li>Integrate data related to targets and outcomes</li> </ul>	X	

Health Service Delivery Model	Options	Responsible Party	
		CIC	Sites
	into IMS/reporting system		
	Leverage local resources to meet TB screening targets and outcomes <ul style="list-style-type: none"> <li>• Public health units</li> <li>• Primary care providers</li> <li>• Universities (e.g. to access medical students and students of other health faculties)</li> </ul>		X
Other Health Services	Carry out regular needs based planning to identify priority health needs identified by GARs		X
	Develop and nurture a strong network of allied providers that are practicing in close proximity or that will delivery services in the community (at the reception centres and/or GARS health service delivery sites) <ul style="list-style-type: none"> <li>• Hold regular networking sessions</li> <li>• Support providers to register with IFH</li> </ul>		X
	Develop collaborative responses to priority health needs with service delivery partners		X

Critical Success Factors	Options	Responsible Party	
		CIC	Sites
Client Centered Care – Global Health Expertise	Develop a program of research and disseminate knowledge regarding refugee health <ul style="list-style-type: none"> <li>• Present at conferences such as Metropolis and the Refugee Health Conference</li> <li>• Actively participate in development of the Refugee Health Conference</li> <li>• Publish and distribute health profiles for refugee groups</li> </ul>	X	X
	Invest in developing expertise in global health <ul style="list-style-type: none"> <li>• Promote staff professional development</li> <li>• Build academic affiliations</li> </ul>	X	X
	Provide global health training for all staff involved in health service delivery when planning for the arrival of new GARs groups and/or populations	X	X
	Identify experts in global health at local universities and among SPOs and engage experts to: <ul style="list-style-type: none"> <li>• Participate in health service delivery</li> <li>• Undertake global health education, research</li> <li>• Support advocacy with policy makers and</li> </ul>		X

Critical Success Factors	Options	Responsible Party	
		CIC	Sites
	funding <ul style="list-style-type: none"> <li>Network with other global health experts to build a strong network of GARs service providers</li> </ul>		
	Sponsor knowledge transfer activities such as networking sessions and workshops with health service delivery partners		X
<b>Client Centered Care – Cultural Competency</b>	Develop standards regarding cultural competence, including definitions, and personal, professional, and organizational assessment tools	X	
	Develop and carry out a training program in cultural competency for the interdisciplinary health service team, including RAP and CSS staff and all health service delivery partners <ul style="list-style-type: none"> <li>Carry out ongoing educational/networking activities to promote continuous learning</li> </ul>	X	X
	Enhance opportunities for health and settlement students to develop cultural competence within the GARs health service delivery model		X
	Increase collaboration with universities and strategic community organizations to gain access to experts in cultural competence		X
	Carry out awareness raising activities in the community to promote sensitivity and awareness regarding GARs issues in the broader community		X
<b>Client Centered Care - Interpretation</b>	Articulate and implement policy and standards regarding interpretation <ul style="list-style-type: none"> <li>Train all sites to apply interpretation standards to service delivery</li> </ul>	X	
	Advocate with the MOHTLC to provide interpretation for health service delivery	X	X
	Educate health service delivery partners as to how to work effectively with interpreters and when they should be used		X
	Inform health service delivery partners use IFH to cover interpretation costs related to initial health assessment		X
	Include interpretation cost sharing agreements as part of the services partnership agreements with health service delivery partners		X
<b>Health Insurance – Ontario Health</b>	Advocate that the MOHLTC to allow reception centres to be exceptions to the OHIP temporary address policy	x	

Critical Success Factors	Options	Responsible Party	
		CIC	Sites
<b>Insurance Plan</b>	Form strong local relationships with local OHIP offices to speed the acceptance of OHIP applications		X
<b>Health Insurance – Interim Federal Health</b>	Enhance awareness raising and training and education activities to promote uptake among health service providers (i.e. Medavie Blue Cross could be contracted to provide these activities)	X	
	Evaluate the impact of the policy change to align with OHIP (e.g. impact of change on the timeliness of coverage on things such as wheelchairs)	X	
	Ensure standards for payment and customer service are outlined in the contract with Medavie Blue Cross	X	
	Monitor the performance of Medavie against standards	X	
<b>Partnerships and Collaboration – CSS/RAP Collaboration and Integration</b>	Clearly define the roles and responsibilities of RAP and CSS in the health service delivery model	X	
	Establish health service performance targets and outcomes for both the RAP and CSS program	X	
	Integrate the targets and outcomes into the RAP and CSS reporting system	X	
	Integrate data regarding targets and outcomes into the existing CSS IMS	X	
	Develop and implement mechanisms for regular and formal communication and/or case management between CSS and RAP (e.g. shared office space, regular planning meetings)		X
	Centralize the approach to the management and oversight of health services		X
	Assign responsibility/oversight/management for health service planning, delivery, and outcomes to one person		X
<b>Partnerships</b>	Facilitate the development of formal relationships with key partners such as universities	X	
	Draw upon the promising practices already underway in the province to strengthen the interdisciplinary nature of health service delivery at each site		X
	Hold quarterly networking meetings with all health service delivery partners to ensure good communication and collaboration		X
	Develop formal mechanisms to share information regularly and routinely with health service delivery partners		X
	Develop formal partnership agreements with all key		X

Critical Success Factors	Options	Responsible Party	
		CIC	Sites
	health service delivery partners		
	Develop and nurture informal partnerships with a broad range of other health and social service providers		X
<b>Performance and Information Management – Planning and Evaluation</b>	Review the CSS information management system to ensure data/information for health service targets and outcomes is being collected, analyzed, and reported	X	
	Integrate the RAP and CSS reporting and information management systems	X	
	Establish and embed information collection and reporting requirements into SPO contribution agreements	X	
	Use CSS and RAP data and information to plan health services	X	X
	Develop and implement an regular approach to planning (e.g. needs based planning process, theory of change, logic model)		X
	Develop planning skills and capacity among RAP and CSS staff		X
	Involve all health service delivery partners in the planning process		X
	Use academic partnerships to carry out research and/or evaluation (e.g. chart audits) in order to produce the data/information required for planning purposes		X
<b>Performance and Information Management – Personal Health History</b>	Mandate compliance with PHIPA a part of the contribution agreement with SPOs	X	
	Settlement staff should be provided with training and education regarding PHIPA	X	X
	Health service delivery partnership agreements should reference to compliance with PHIPA		X
<b>Performance and Information Management – Health History</b>	Evaluate the pilot project underway to share the IME and determine whether to expand the project to other sites	X	
	Leverage local resources (e.g. medical residents) to carry out a medical history that can be shared with the GARs' family physicians		X

## Recommendations

This section presents the recommendations identified through the synthesis, analysis, and refinement of the options presented above. An important input for the development of the recommended health service delivery model and implementation priorities was the review of the options presented in the previous section that took place at the provincial workshop held on November 28 and 29, 2011.

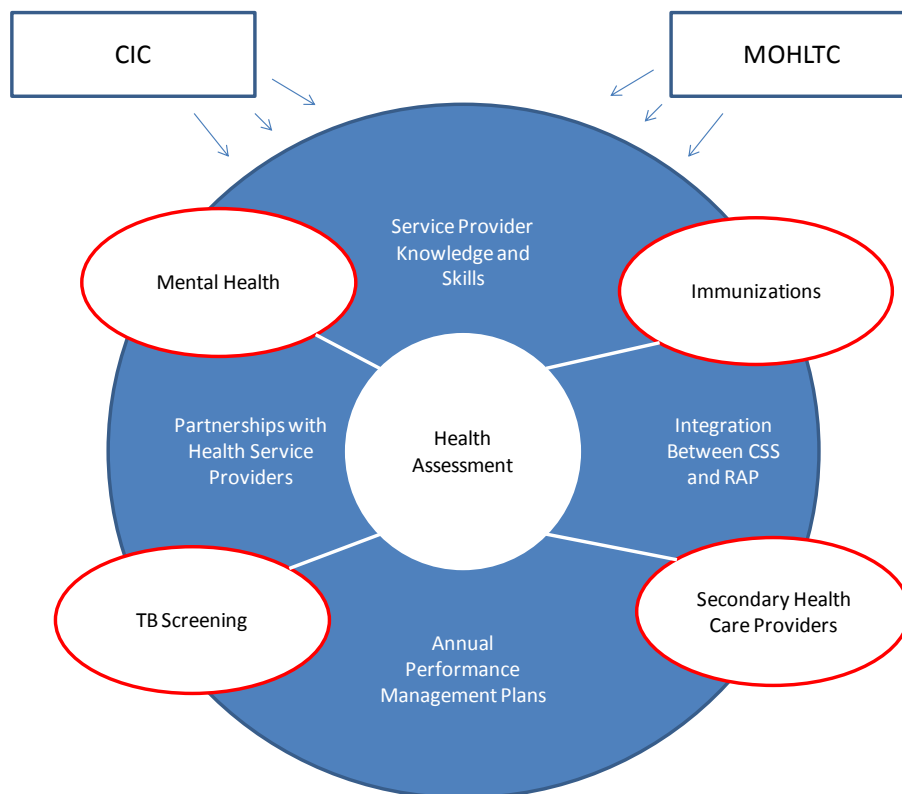


Figure 29: Recommended Health Service Delivery Model with Critical Success Factors

It is recognized that health services are already being delivered to GARs at the six GARs receiving sites in Ontario. By leveraging the promising practices already underway, a standard health service delivery model for GARs, as presented in Figure 29, is recommended.

In this model:

- All GARs have access to and receive a health assessment from a primary care provider within 10 days of their arrival in Ontario
- The health assessment addresses GARs health and wellbeing in a holistic way and integrates the following components:
  - Mental health
  - TB screening
  - Immunizations



- Referrals to other health care providers to address other health care needs such as oral health, optometry, nutrition, etc.
- Health services are funded and managed by the MOHLTC and its transfer payment agencies with the exception of IFH which is funded and managed by CIC;
- The primary role and responsibility of the settlement service providers (RAP and CSS) is initiate and enter into partnerships with health service providers to facilitate access to the health service delivery model for GARs at each of the six sites in Ontario
- Success factors can be attributed to:
  - Partnership and collaboration between settlement and health service providers
  - Alignment between federal and provincial health insurance and funding programs
  - Knowledge transfer and communication
  - Information and performance management.

The recommendations described in this section will support the implementation of this model and are divided into three main categories as outlined in the table below.

Categories	Number	Recommendation
<b>A. Health Service Delivery Model</b>	1	Develop GARs Health Service Delivery Policy
	2	Develop Health Service Delivery Model Standards
	3	Align Local Health Service Delivery Model with Provincial Model and Standards
<b>B. Health Service Delivery Funding and Insurance Plans</b>	4	MOHLTC Recognition of GARs as a Priority Population
	5	Develop a Funding Model for GARs Health Services
	6	Align OHIP Temporary Address Policy with CIC GARs Resettlement Policies
	7	Assess Changes to IFH and Address Areas of Conflict
	8	Enhance IFH Education and Training
<b>C. Critical Success Factors</b>	9	Strengthen the Integration between CSS and RAP staff
	10	Enhance Service Provider Knowledge and Skills
	11	Enhance Partnerships with Health Service Providers
	12	Develop an Annual Performance Management Plan

Each of the recommendations is presented and described in detail in this section, and each recommendation includes:

- Brief description
- Rationale
- Implementation considerations (see table below)
- Primary impact

<b>Implementation Considerations</b>	
<b>Criteria</b>	<b>Description</b>
<b>Investment timeline</b>	The timeline of the investment required by CIC and the six sites, short-term or ongoing.
<b>Investment cost</b>	The cost of the investment required by CIC and/or the settlement agencies, both capital and operating.
<b>Alignment with COIA</b>	The extent to which recommendations are aligned with COIA strategies, modernization and an outcomes based approach (see Appendix E).
<b>Alignment with health priorities</b>	The extent to which recommendations are aligned with MOHLTC and public health strategies and/or priorities (see Appendix F and G).
<b>Engagement of health partners</b>	The extent to which recommendations are dependent on the engagement of health partners.
<b>Support of service providers</b>	The extent to which actions would be well received by settlement and health service providers at the six sites.

The recommendations have been notionally prioritized for implementation with the use of evaluation criteria. The evaluation criteria draw and expand upon the decision making criteria that were developed by the settlement and health sector service providers during the provincial workshop. At the workshop, participants identified that in order to prioritize an option for implementation the option must:

- Have sufficient and sustainable resources to enable implementation of the option
- Have stakeholder support at the local, community, provincial, and/or federal level(s)
- Promote a provincial standard
- Have measureable positive outcomes and objectives
- Be responsive to clients and/or be client-centred
- Foster improved and more formalized community partnerships
- Increase the capacity of service providers
- Be evidence informed
- Take into account the broader social determinants of health and all the services in which they are involved
- Have benefits that outweigh the risks or mitigation strategies for the risks.

Please refer to the next section for information about how the recommendations have been prioritized for implementation.

## A. Primary Care Service Delivery Model Recommendations

### Recommendation 1: Develop GARs Health Service Delivery Policy

It is recommended that CIC, National Headquarters and/or CIC, Ontario Region develop a policy framework regarding the delivery of health services to GARs upon their arrival in Ontario.

#### Rationale

There is a lack of a policy framework to guide the delivery of health services to GARs. This results in the inconsistent delivery of services and differential access to health services for GARs. This also exacerbates the lack of agreement among settlement and health service providers as to whether all or some GARs should receive health assessments and how and when, relative to the GARs arrival, these should be provided. Finally, with inconsistency in service delivery, the ability to collect or understand province-wide information regarding GARs health needs in the short and/or long term is limited.

This study suggests that there is a need for the development of an overarching policy on GARs health. The development of such a health policy framework will provide the mandate, vision, values, and guiding principles upon which standards and subsequently health services to GARs would be developed, provided, and evaluated in Ontario and ideally in other GARs receiving jurisdictions across Canada.

#### Activities

- CIC to carry out research regarding GARs health policy in other jurisdictions
- CIC to consult with both internal and external stakeholders
- CIC to draft policy framework

#### Considerations for Implementation

Investment timeline	Investment cost	Alignment w/ COIA	Alignment w/ health priorities	Engagement of health partners	Support of service providers
Short term with regular review	Capital <ul style="list-style-type: none"><li>• None</li><li>• Low operational (staffing)</li></ul>	Yes	Yes	Yes	Yes

#### Primary Impact

A health service delivery policy for GARs will provide the foundation for the development and implementation of standards regarding access to and delivery of health services to GARs during their first year in Ontario.

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## Recommendation 2: Develop GARs Health Service Delivery Standards

It is recommended that CIC, Ontario Region develop provincial standards that will guide the development and implementation of a standardized health service delivery model for GARs in Ontario. These standards minimally include:

- All GARs should have access to and receive a health assessment from a primary care provider within the first 10 days of their arrival in Ontario
- The health intake should integrate the following GARs health needs in a manner that is consistent with clinical practice guidelines :
  - Mental health
  - Immunizations
  - TB screening
  - Referrals to other health services as required by GARs

To ensure the successful achievement of these standards, it is recommended that performance targets for each of the standards listed above be included in CIC's contribution agreements with its settlement service providers.

### *Rationale*

There is a lack of health service delivery standards to support consistent access to high quality health services for GARs and to guide the delivery of those services by health service delivery partners in Ontario. This has resulted in, and further exacerbates, the lack of agreement among service providers as to whether all or some GARs should receive health assessments as well as the nature of the other health services provided. Finally, without standards, the ability to collect or understand province-wide information regarding GARs health needs and outcomes in the short- and/or long-term is limited.

This study suggests that there is a need for the development of province-wide standards that will provide the sector with a consistent approach to facilitating access and delivering health services to GARs. The study also shows that there is an opportunity to leverage the promising practices underway across the sites in the delivery of health assessments, mental health services, immunizations, TB screening, and other health services such as optometry and dental care to GARs.

### *Activities*

- CIC to carry out research regarding GARs health service delivery standards in other jurisdictions
- CIC to develop standards for settlement service providers regarding facilitating access to and delivery of health services to GARs in Ontario
- CIC to consult with stakeholders regarding the standards

### *Considerations for Implementation*

<b>Investment timeline</b>	<b>Investment cost</b>	<b>Alignment w/ COIA</b>	<b>Alignment w/ health priorities</b>	<b>Engagement of health partners</b>	<b>Support of service providers</b>
<ul style="list-style-type: none"><li>• Short term to develop the standards</li><li>• Periodic review of standards</li></ul>	Capital <ul style="list-style-type: none"><li>• None</li><li>• Operating</li><li>• Low</li></ul>	Yes	Yes	Yes	Yes

### *Primary Impact*

The development of province-wide standards will provide the settlement sector with a consistent approach for facilitating access to and delivery of health services to GARs.

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### **Recommendation 3: Align Local Health Service Delivery Model with Provincial Model and Standards**

It is recommended that the six GARs receiving sites in Ontario develop and implement a health service delivery model that is aligned with the CIC provincial standards. Minimally, each GARs receiving site in Ontario will provide the following:

- All GARs should have access to and receive a health assessment from a primary care provider within the first 10 days of their arrival in Ontario
- The health intake should integrate the following GARs health needs in a manner that is consistent with clinical practice guidelines :
  - Mental health
  - Immunizations
  - TB screening
  - Referrals to other health services as required by GARs
- In each of the GARs receiving sites, local RAP and CSS programs should work in partnership with their local primary care service delivery partner(s) to develop a service delivery model that is aligned with the standards as identified in Recommendation 2.

#### ***Rationale***

The implementation of a standard health service delivery model across Ontario will support the consistent delivery of high quality health services and access to health services for GARs arriving at each site and across the province. This recommendation will:

- Ensure GARs have equal access to a health assessment and health services, regardless of where in Ontario they are resettling
- Support settlement service providers and community partners to deliver consistent health services to GARs
- Facilitate enhanced information sharing and learning among the providers
- Support improved planning, information collection and reporting, and evaluation of services to GARs

The study shows that there is an opportunity to leverage the many promising practices already underway across the sites in the delivery of health and mental health assessments and services, immunizations, TB screening, and other health services, such as optometry and dental care, to GARs.

#### ***Activities***

- Settlement and health service providers at each site to meet to review the provincial standards for service delivery to GARs in Ontario
- Settlement and health service providers at each site to develop a plan to implement the standards

### *Considerations for Implementation*

<b>Investment timeline</b>	<b>Investment cost</b>	<b>Alignment w/ COIA</b>	<b>Alignment w/ health priorities</b>	<b>Engagement of health partners</b>	<b>Support of service providers</b>
<ul style="list-style-type: none"> <li>• Short term to establish the model;</li> <li>• Some sites may need ongoing funding to coordinate activities</li> </ul>	Capital <ul style="list-style-type: none"> <li>• Low; some sites may require new or improved clinical space</li> </ul> Operating <ul style="list-style-type: none"> <li>• Medium; some sites may require additional funding for coordination</li> </ul>	Yes	Yes	Yes	Yes

### *Primary Impact*

The application of province-wide standards at the site level will ensure that GARs arriving at any of the six sites in Ontario will consistently have access to health services.

## B. Health Service Delivery Funding and Insurance Plans Recommendations

### Recommendation 4: MOHLTC Recognition of GARs as a Priority Population

It is recommended that CIC engage in discussions with the MOHLTC to negotiate for the recognition of GARS as priority population for health services funding and program delivery.

#### Rationale

The planning and provision of health services for residents of Ontario is a responsibility that rests with the province of Ontario and specifically the MOHLTC. As CIC does not fund or deliver health services, the policy framework and standards developed by CIC will be limited to facilitating access to health services. While CIC and its SPOs can work to enhance access to health service by developing partnerships with health service providers, SPOs do not independently deliver health services, unless they are multi-service organizations mandated and funded to deliver health services.

To impact the overall health outcomes of Ontario's population, targeted approaches are required with specific populations where evidence points to health inequities or where a sub-group of the population is disadvantaged in terms of their health outcomes. In the Ontario Public Health Standards (OPHS), these groups are called "priority populations". Greater gains to the overall health of the population may be made by reducing health inequities within a population and by focusing efforts on these priority populations. To ensure the sustainability of the proposed health service delivery model, it is recommended that CIC engage in discussions with the MOHLTC to identify GARs as a priority population for health services in Ontario. This will increase the ability of the sites to attract the interest of local health service providers as partners. In addition, it will better position health service partners to access funding for GARs specific health service delivery (e.g. nurse practitioner led clinics).

#### Activities

- CIC, Ontario Region to set up a meeting with CIC's intergovernmental relations department to discuss federal /provincial roles and responsibilities related to the development of a provincial framework/policy for GARs health service funding and delivery
- CIC to develop business case for discussions with MOHLTC
- CIC to meet with MOHLTC

#### Considerations for Implementation

Investment timeline	Investment cost	Alignment w/ COIA	Alignment w/ health priorities	Engagement of health partners	Support of service providers
<ul style="list-style-type: none"><li>• Short term</li></ul>	Capital <ul style="list-style-type: none"><li>• None</li><li>• Operating</li><li>• Low</li></ul>	Yes	Yes	Yes	Yes

#### Primary Impact

Negotiating with the MOHLTC to recognize GARs as a priority population will enhance access to services and health outcomes for an equity seeking population.



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## Recommendation 5: Develop a Funding Model for GARs Health Services

It is recommended that CIC engage in discussions with the MOHLTC to negotiate and coordinate roles and responsibilities, particularly as these relate to the funding of the GARs health service delivery model.

### Rationale

As previously mentioned, the planning and provision of health services for residents of Ontario is a responsibility that rests with the province of Ontario and specifically the MOHLTC and the Local Health Integration Network (LHINs). As CIC does not fund or deliver health services, the six sites are reliant on the good will of local health service delivery partners. At the same time, the MOHLTC has not identified GARs as a priority equity population and therefore there is no provincial framework or policy to guide the delivery health services to this population.

To ensure the implementation and sustainability of the proposed health service delivery model for GARs in Ontario, it is recommended that CIC engage in discussions with MOHLTC to define federal and provincial roles and responsibilities for the delivery and funding of health services to GARs. Further, it is suggested that the promising practices identified in this report be used as a starting point for determining how CIC and MOHLTC may work together to fund the delivery of health services. Two notable examples include:

- Windsor – MCC has received funding from both CIC and the MOHLTC. While CIC staff coordinate the access of GARs to health services, the MOHLTC funded nurse practitioner coordinates and delivers health services
- Ottawa – Catholic Immigration Centre staff coordinate the access to health services for GARs while LHIN funded staff employed by the Somerset West CHC, including the GARs health clinic coordinator, nurse practitioners and physicians, coordinate and deliver health services

### Activities

- CIC, Ontario Region to set up a meeting with CIC's intergovernmental relations department to discuss federal /provincial roles and responsibilities related to funding for GARs health services
- CIC to develop business case for discussions with MOHLTC
- CIC to meet with MOHLTC

### Considerations for Implementation

Investment timeline	Investment cost	Alignment w/ COIA	Alignment w/ health priorities	Engagement of health partners	Support of service providers
<ul style="list-style-type: none"><li>• Short term</li></ul>	Capital <ul style="list-style-type: none"><li>• None</li><li>• Operating</li><li>• Low</li></ul>	Yes	Yes	Yes	Yes

### *Primary Impact*

Clarifying federal and provincial roles and responsibilities related to the funding and provision of health services to GARs would ensure that the proposed health service delivery model is both implemented and sustained.

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### **Recommendation 6: Align OHIP Temporary Address Policy with CIC Resettlement Policies**

It is recommended that CIC engage with the MOHLTC to align the OHIP temporary address policy with the CIC resettlement policy of providing temporary housing to GARs upon arrival. This would allow GARs arriving at any of the six sites to qualify for OHIP while they are residing at the reception centres.

#### ***Rationale***

At this time, there is inconsistent practice among local OHIP offices regarding temporary addresses. Four of the six sites report that their local OHIP office accepts the reception centre as a temporary address for GARs and issues OHIP immediately on this basis. Two of the sites, however, are not able to secure OHIP for the GARs until they transition from the reception centre to permanent accommodation, thereby delaying access to OHIP and coverage for critical health services, for example assisted services and devices provided by community care access centres.

As a matter of policy, GARs are entitled to OHIP upon their arrival in Ontario. Unfortunately, the federal government's resettlement program (which provides transitional housing for GARs) is in conflict with provincial OHIP policy. Ultimately, the lack of coordinated policy and practice at the federal and provincial levels has a negative impact on GARs.

As such, this study recommends that CIC engage with the MOHLTC to negotiate the alignment OHIP's temporary address policy with its resettlement policy. This will ensure that GARs do receive OHIP upon arrival in Ontario, as entitled and there is timely access to consistent health services for GARs in Ontario.

#### ***Activities***

- CIC, Ontario Region to raise issues related to OHIP with CIC's intergovernmental relations department
- CIC to develop business case for discussions with MOHLTC
- CIC to meet with MOHLTC
- Sites to identify a representative(s) at each site to enter into discussions with the local OHIP office
- Site RAP manager to meet with OHIP office to confirm a common approach to the application and approval of GARs coverage

#### ***Considerations for Implementation***

<b>Investment timeline</b>	<b>Investment cost</b>	<b>Alignment w/ COIA</b>	<b>Alignment w/ health priorities</b>	<b>Engagement of health partners</b>	<b>Support of service providers</b>
<ul style="list-style-type: none"><li>• Short term</li></ul>	Capital <ul style="list-style-type: none"><li>• None</li><li>• Operating</li><li>• Low</li></ul>	Yes	Yes	Yes	Yes

#### ***Primary Impact***

Policy alignment would ensure that GARs at all of the six receiving cities in Ontario would qualify for OHIP coverage while living at the reception centres.

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### **Recommendation 7: Assess Changes to IFH and Address Areas of Conflict**

It is recommended that CIC, National Headquarters monitor and evaluate the impact on GARs of IFH claimable services and products in relation to the changes made to align more closely with OHIP and subsequently adjust IFH to address any observed areas of conflict.

#### ***Rationale***

The services and products claimable under IFH were revised to eliminate redundancies between IFH and OHIP coverage. These changes coupled with the discrepancies in the timeframe within which OHIP coverage for GARs is approved have resulted in a delay or inability on the part of health and settlement service providers to access services and products on behalf of GARs.

This study suggests that it may be timely for CIC to monitor and evaluate IFH claimable services to ascertain whether there are any remaining redundancies or gaps relative to OHIP coverage and address them. This would ensure that GARs have the same access to health services and products under their insurance coverage regardless of the site in Ontario to which they arrive.

#### ***Activities***

- Review the IFH and OHIP coverage to ensure there are no gaps in coverage when the timeframes of OHIP coverage are aligned, as per Recommendation 6
- Inform CIC, Ontario Region, settlement workers, and registered health service providers of any gaps that exist in coverage
- Address any gaps in coverage by enhancing IFH coverage

#### ***Considerations for Implementation***

<b>Investment timeline</b>	<b>Investment cost</b>	<b>Alignment w/ COIA</b>	<b>Alignment w/ health priorities</b>	<b>Engagement of health partners</b>	<b>Support of service providers</b>
<ul style="list-style-type: none"><li>• Short term</li></ul>	Capital <ul style="list-style-type: none"><li>• None</li><li>• Operating</li><li>• Low</li></ul>	Yes	Yes	Yes	Yes

#### ***Primary Impact***

Addressing issues related to IFH coverage would ensure that GARs have the same access to health services and products under their insurance coverage regardless of the site in Ontario to which they arrive.

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### **Recommendation 8: Promote IFH to Service Providers through Education and Training**

It is recommended that CIC, National Headquarters negotiate /contract with IFH to promote the IFH program with health service providers by enhancing the current level of education and training regarding IFH claimable health services and products, registration, and billing processes. This will increase the roster of registered providers and improve customer relations.

#### ***Rationale***

IFH continues to suffer from a negative perception in the eyes of many health service providers as a result of experiences with the previous provider. In addition, it is reported that settlement staff spend considerable time working with health service providers to educate and train them on IFH processes. This is reported to be due to a lack of available training and support from IFH and to counteract the reluctance of health providers to register with IFH unless supported by the sites.

By promoting the IFH program to health service providers through enhanced education and training activities, IFH could reduce health service provider frustration with the IFH processes. This could also result in increased registration rates of health service providers with IFH. At the same time, settlement staff could divert to their clients the time they currently spend supporting health service providers with IFH processes and issues. Further, an augmented roster would increase GARs access to health services and products.

#### ***Activities***

- CIC, Ontario Region to identify the areas in which IFH education and training is needed for health service providers
- CIC, Ontario Region inform CIC, National Headquarters of the areas in which IFH education and training is needed for health service providers
- CIC, National Headquarters to negotiate with/contract IFH to enhance education and training to health service providers
- IFH to disseminate negotiated/contracted education and training

#### ***Considerations for Implementation***

<b>Investment timeline</b>	<b>Investment cost</b>	<b>Alignment w/ COIA</b>	<b>Alignment w/ health priorities</b>	<b>Engagement of health partners</b>	<b>Support of service providers</b>
<ul style="list-style-type: none"><li>• Short term and ongoing</li></ul>	<ul style="list-style-type: none"><li>• Capital</li><li>• None</li><li>• Operating</li><li>• Low</li></ul>	Yes	Yes	Yes	Yes

#### ***Primary Impact***

Promoting IFH through enhanced education and training to health service providers would increase positive perception of the provider and the program, decrease the time settlement workers spend educating/supporting health service providers, and increase GARs access to health services and products.

## C. Critical Success Factor Recommendations

### Recommendation 9: Strengthen the Integration between CSS and RAP staff

It is recommended that all sites strengthen the integration between CSS and RAP staff.

#### *Rationale*

This study demonstrated that GARs health needs are a priority need from the time of their arrival and throughout their first year after arrival in Ontario. Therefore, facilitating access to health services is the responsibility of both the RAP and CSS staff who are engaged with GARs during this period.

Implementation of the proposed health service delivery model requires coordination between health service delivery partners and RAP and CSS staff. Timely communication and follow-up between RAP and CSS staff, particularly as the GARs move from the reception centres to their permanent residences is critical to ensure that the GARs are tracked during the transition, that new contact information is communicated with health service providers and to promote continuity of care with health service providers.

At most sites CSS and RAP staff already coordinate their activities through regular meetings, by working in close proximity to one another, or through centralized management. It is recommended that the sites enhance their efforts to integration CSS and RAP to minimize redundancy of activities, increase continuity of care to GARs and to facilitate communication between health service providers, settlement providers, and GARs.

#### *Activities*

- Establish regular meetings between RAP and CSS staff
- Increase communications links between RAP and CSS, e.g. email communications, working in the same offices
- CSS and RAP develop a process to plan the orientation of GARs together to ensure access to health services
- CSS and RAP develop a process for joint case management for GARs to ensure that health needs are addressed

#### *Considerations for Implementation*

Investment timeline	Investment cost	Alignment w/ COIA	Alignment w/ health priorities	Engagement of health partners	Support of service providers
<ul style="list-style-type: none"><li>• None</li></ul>	Capital <ul style="list-style-type: none"><li>• None</li><li>• Operating</li><li>• Low</li></ul>	Yes	N/A	N/A	N/A

#### *Primary Impact*

Increased integration between RAP and CSS will result in enhanced quality of health services and continuity of care for GARs.

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### **Recommendation 10: Enhance Service Provider Knowledge and Skills**

It is recommended that CIC, Ontario Region, the six sites and their health service delivery partners develop and implement a coordinated approach to providing/arranging for the orientation and ongoing education/training of settlement staff and health service providers in the following areas:

- Cultural competence
- Global health knowledge
- PHIPA
- Working with interpreters

#### ***Rationale***

There are discrepancies in the level of knowledge, training and education settlement staff and health service providers at the six sites in Ontario have about health policy/GARs/ GARs health. For example, most settlement staff do not have a clear understanding of PHIPA or how PHIPA applies to their work with GARs and their communication with health service providers. Other areas for learning that were specifically highlighted during the course of this study include global health knowledge, cultural competence and working with interpreters.

A professional development program for settlement staff and health service providers that includes an initial orientation to the GARs health service delivery model as well as ongoing education and training for settlement staff and health service providers would enhance:

- Client-centred care with appropriate awareness of culture and its application to health service delivery
- Knowledge of global health and the ability of health service providers to identify health issues and provide health assessments and treatment
- Efficiency and effectiveness of communication between GARs, settlement workers, health service providers due to a stronger understanding of health policies such as PHIPA and the application of policy in service delivery
- Access to and quality of health services through the effective utilization of interpreters

#### ***Activities***

- CIC, Ontario Region to develop a protocol for the delivery of initial orientation to the GARs health service delivery model
- CIC, Ontario Region to develop a protocol to guide the ongoing education and training of settlement service providers at the six sites engaged in health service delivery to GARs
- Sites to meet with their health service delivery partners to develop a process for implementing a process for ongoing education and training

### *Considerations for Implementation*

<b>Investment timeline</b>	<b>Investment cost</b>	<b>Alignment w/ COIA</b>	<b>Alignment w/ health priorities</b>	<b>Engagement of health partners</b>	<b>Support of service providers</b>
<ul style="list-style-type: none"><li>• Ongoing</li></ul>	Capital <ul style="list-style-type: none"><li>• None</li><li>• Operating</li><li>• Low</li></ul>	Yes	Yes	Yes	Yes

### *Primary Impact*

Orientation and ongoing education for settlement staff and health service provider in cultural competence, global health knowledge, health policy (PHIPA), and working with interpreters will enhance GARs-centred care, communication between health service providers and settlement workers and GARs access to quality health services.



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### **Recommendation 11: Partnerships with Health Service Providers**

It is recommended that sites enter into formal partnerships with health service providers such as hospitals, universities, Community Health Centres (CHCs), Family Health Teams (FHTs), and Public Health Units in order to implement the proposed health service delivery model and to enhance/increase their access to:

- Global health and cultural competency experts
- Health service providers
- Training/in-service resources
- Client case management
- Research
- Advocacy with decision makers

#### ***Rationale***

Each of the six sites in Ontario has developed primarily informal partnerships with a number of health service providers. This study suggests that there are benefits to formalizing partnerships with an extensive range of health service organizations. These have been cited previously in the findings and options for improvement section of this report and include:

- Access to global health and cultural competency experts can increase health service delivery outcomes such as enhanced GARs-centred health services and improved health interpretation
- Partners with expertise in global health and cultural competency can be leveraged to provide education and training to settlement staff and health service providers
- Formal partnerships between settlement agencies and health service organizations can ensure the sustainability of health services that are not based on personal but rather on formal contractual relationships
- Formal partnership arrangements can promote better communication between the sites, health service providers and GARs
- Formal partnerships agreements clearly describe roles and responsibilities and can enhance GARs access to timely and appropriate services
- Health service partners can be drawn upon to provide health education and promotion services and group programs to GARs
- Partnerships have proven to generate research and knowledge for dissemination when they include students, professors, residency programs, and universities. Partnerships can contribute to the limited research on GARs health and health service delivery in Ontario and Canada
- Increasing the number and diversity of health service providers interested in and working with GARs will enhance advocacy efforts with decision makers to achieve equity for this priority population.

### *Activities*

- Sites identify potential health service partners
- CIC, Ontario Region develop materials to support sites in developing partnerships and partnership agreements with diverse health sector service providers
- Sites to develop health service delivery engagement plans to increase the number of health service delivery partners and/or the strengths of those partnerships

### *Considerations for Implementation*

<b>Investment timeline</b>	<b>Investment cost</b>	<b>Alignment w/ COIA</b>	<b>Alignment w/ health priorities</b>	<b>Engagement of health partners</b>	<b>Support of service providers</b>
<ul style="list-style-type: none"><li>• Ongoing</li></ul>	Capital <ul style="list-style-type: none"><li>• None</li><li>Operating</li><li>• Low</li></ul>	Yes	Yes	Yes	Yes

### *Primary Impact*

Expanding, strengthening and formalizing partnerships with health service organizations would increase access to:

- Global health and cultural competency experts
- Health service providers
- Training/in-service resources
- Client case management
- Research
- Advocacy with decision makers

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## **Recommendation 12: Develop an Annual Performance Management Plan**

It is recommended that the six GARs receiving sites in Ontario develop and use an annual performance management plan to assess and develop a local response to GAR health needs and to monitor and evaluate the effectiveness of the health services delivered to GARs at the local level.

### ***Rationale***

At this time, RAP and CSS service providers are not contractually obligated through their contribution agreements with CIC to facilitate access to and/or deliver health services to GARs. Consequently, there are no performance targets or objectives to guide the sites in carrying out or monitoring their performance vis a vis health related activities or services.

It is recommended that the six sites work together with their health service delivery partners to develop an annual performance management plan for the proposed health service delivery model. This plan should include the objectives and targets that have been outlined by CIC for the standard health service delivery model as well as a plan for measuring performance against the targets.

Further, the sites and their health service delivery partners should undertake regular needs based planning and evaluation, drawing upon information collected by RAP and CSS needs assessments and from data or information produced by their health service delivery partners. As a part of the needs based planning process, performance management targets or objectives should be reviewed to ensure that they reflect changing needs of GARs at the local level.

### ***Activities***

- CIC, Ontario Region to support site managers (e.g. by offering training, sharing templates, facilitating planning sessions, etc.) to develop a standard performance management plan
- Site managers to work together with their health service delivery partners to develop a performance management plan that includes:
  - Identifying performance targets for the RAP and CSS program (incorporating those that CIC developed for the health service delivery model)
  - Performance targets identified by the local health service delivery partners
  - A monitoring and reporting schedule
- Site managers to work with their health service delivery partners to carry out an annual evaluation and needs based planning exercise to ensure targets and objectives are aligned with local needs
- Sites and CIC, Ontario Region to work together to establish a reporting framework
- Sites and CIC, Ontario Region to work together to establish a means of sharing reporting and planning with site staff and health partners

### *Considerations for Implementation*

<b>Investment timeline</b>	<b>Investment cost</b>	<b>Alignment w/ COIA</b>	<b>Alignment w/ health priorities</b>	<b>Engagement of health partners</b>	<b>Support of service providers</b>
<ul style="list-style-type: none"><li>• Ongoing</li></ul>	Capital <ul style="list-style-type: none"><li>• None</li><li>• Operating</li><li>• Low</li></ul>	Yes	Yes	Yes	Yes

### *Primary Impact*

Increased ability to monitor and evaluate CIC and its settlement service providers' ability to meet GARs health needs and improve their health outcomes.

## Implementation

CIC, Ontario Region, the YMCA, Toronto, the six settlement agencies in GARs receiving sites across Ontario and their health service delivery partners have been highly involved in the study and development of the options and recommendations put forward in this report. People involved in this work have placed confidence in this project and its process, and are eagerly awaiting the findings in this report. Therefore this implementation plan has been developed for CIC to support the implementation of key recommendations as quickly as possible.

Based on the promising practices and work accomplished through this study there is momentum for the implementation of a standard health service delivery model and the associated recommendations. Indeed, all stakeholders involved in this study have already made significant progress in facilitating access to and/or providing health services to GARs.

This section puts forward an approach for the implementation of the report's recommendations. It is recommended that CIC, Ontario Region use this high level implementation plan to develop a detailed project plan as well as a communications plan and a stakeholder engagement plan. These are critical to the successful implementation of these recommendations. Responsibility for effective and communications with stakeholders will need to be clearly assigned to the appropriate CIC lead(s).

This report proposes and describes best practices for a standard health service delivery model for GARs. The recommendations being put forward to CIC, Ontario Region to support the implementation of the proposed health service delivery model as described in this report are:

1. Develop a GARs health service delivery policy
2. Develop GARs health service delivery model standards
3. Align local health service delivery with the CIC policies and standards
4. MOHLTC recognition of GARs as a priority population
5. Develop a funding model for GARS health services
6. Align OHIP temporary address policy with GARs OHIP and resettlement policies
7. Assess changes to IFH and address areas of conflict
8. Enhance service provider education and training
9. Strengthen the integration between CSS and RAP staff
10. Enhance partnerships with health service providers
11. Develop an annual performance management plan

## Implementation Plan

Successful implementation of these recommendations requires a detailed implementation plan. This section presents a high level plan to support CIC with implementation planning.

### A Phased Approach

Not all recommendations can be implemented at one time. If CIC and the sector take on too many activities/projects at one time, the result will be that few of the activities/projects will get completed on target or with the quality desired. Consequently this report suggests a phased approach to implementation as described in the timeline provided in figure 30. The sequencing of the recommendations:

- Takes into account the decision making criteria for priority setting as presented in the previous section;
- Ensures that dependent recommendations are performed in the correct order;
- Ensures that stakeholders are not overwhelmed by the amount and degree of change required;
- Reflects the need to utilize resources appropriately, and
- Leverages current practices already established at sites to achieve short term benefits while at the same time planning and initiating subsequent projects.

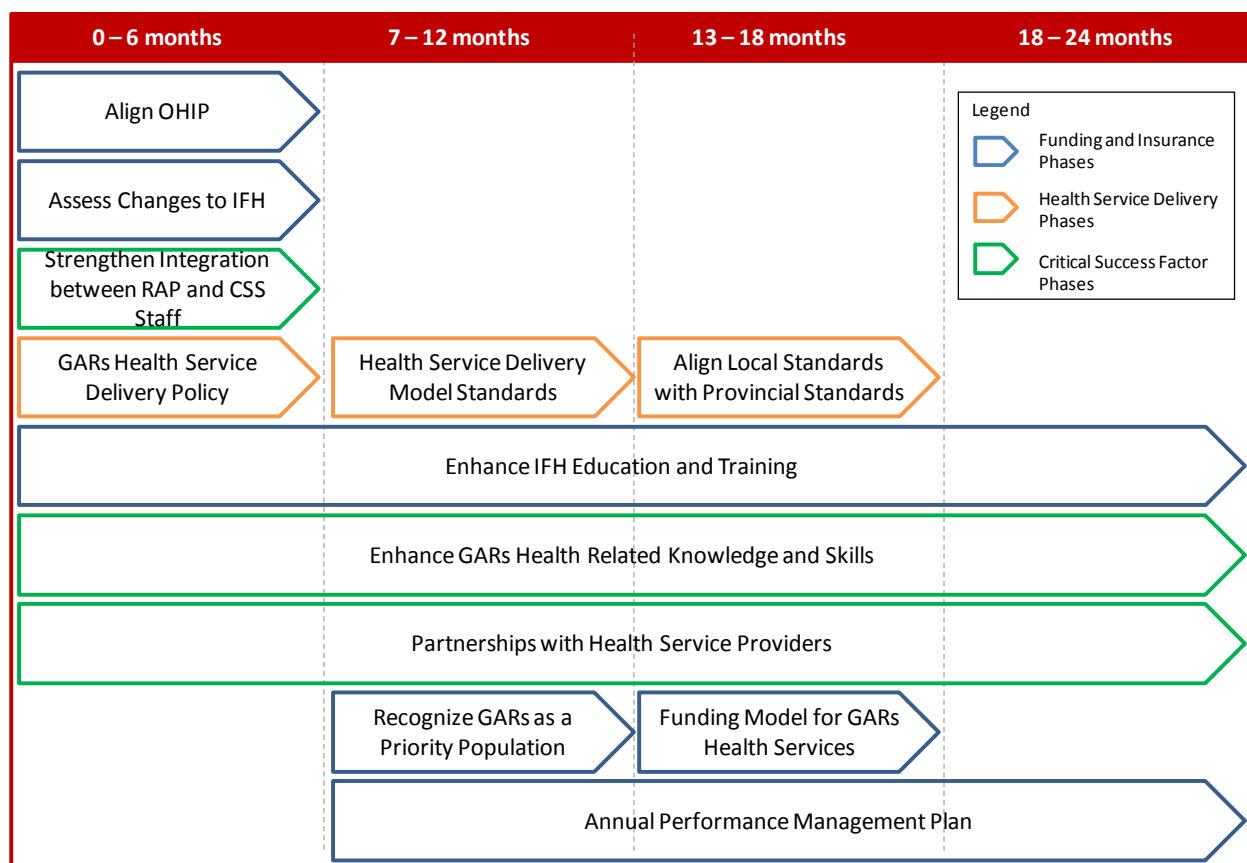


Figure 30: High Level Implementation Timeline

### **Involvement of the Settlement Sector**

To ensure that the health service delivery model and recommendations envisioned in this report are developed and implemented in a sustainable manner, the involvement of key stakeholders from the settlement and health sectors is required. As a result stakeholders have an expectation that action will be taken to develop a standard approach to GARs health service delivery. They also expect to receive communication regarding the report's recommendations and to be consulted and involved as recommendations are implemented.

### **Project Performance Metrics**

Each of the recommendations should be undertaken as a project. In order for CIC to ensure that their objectives are clear and being met, performance metrics need to be developed and integrated into these projects. This will assist all stakeholders to be clear about what is to be achieved, how it will be achieved, and measure if they have been successful.

### **Effective Project Management and Change Management**

With the number of recommendations, resulting actions, variety of stakeholders, and types of issues, success will require effective project and program management. This will be critical to ensure the objectives are well defined and understood, and that the scope, resources, tasks, timing and risks are effectively and efficiently managed. Good project management also ensures effective reporting and communications to senior management and key stakeholders.

### **Risk Management**

Risk management is a good project management practice to employ in the implementation of projects, in particular complex, multi-faceted, and multi-phased initiatives. It is recommended that time be spent up-front identifying potential risks and developing mitigating strategies.

## Conclusion

This study demonstrated that health is the primary need identified by GARs throughout their first year in Ontario and that health is a settlement need and access to health services a service delivery priority. At this time, settlement service providers (e.g., RAP and CSS staff) are working hard to provide these services, but do so without a policy framework or standards to guide their activities.

To this end, the study proposed a standard health service delivery model wherein all GARs arriving in Ontario have access to a primary care assessment that integrates mental health, immunizations, TB screening and referrals to address broader health care issues. Further this study leverages the promising practices already underway in Ontario to address GARs health needs and presents a series of recommendations and a plan for implementing a standard health service delivery model.

Settlement service providers are highly eager to improve health service delivery to GARs while at the same time there is increasing interest in GARs being expressed by the health sector, including service providers, researchers and provincial health funding bodies. CIC, Ontario Region is receiving this report at an opportune time and is well positioned to respond to the proposed recommendations.



## Appendices

### Appendix A: Interview and Roundtable Discussion Participants

Site	Name	Organization
	Fiona Corbin	Citizenship and Immigration Canada, Ontario Region
	Katarina Canic	YMCA of Greater Toronto
<b>Hamilton</b>	Ahmed Mohammed	Wesley Urban Ministries
	Anita	Wesley Urban Ministries
	Jenney Josipovic	Wesley Urban Ministries
	Daljit Garry	Wesley Urban Ministries
	Rose	Hamilton Public Health Unit
	Marcia Matthews	Hamilton Public Health Unit
	Rahia	Hamilton Urban Core CHC
<b>Kitchener-Waterloo</b>	Mira Malidzanovic	Reception House
	Lynne Griffiths-Fulton	Reception House
	Dr. Neil Arya	Centre for Family Medicine
	Gillian McKenzie-Yorke	University of Waterloo Optometry Clinic
	Dr. Hayhoe	University of Waterloo Optometry Clinic
	Gillian Wells	MOSAIC
	Gwen McIntyre	Region of Waterloo Public Health – Vaccine and Preventable Disease Program
	Mary Mueller	Region of Waterloo Public Health - Reproductive Health Program
	Glenna Murray	Region of Waterloo Public Health - TB clinic
<b>Ottawa</b>	Chamroeun Lay	Catholic Immigration Centre
	Nadia Youssef	Somerset West Community Health Centre
	Paula Day	Somerset West Community Health Centre
	Lucila Cabrera	Catholic Immigration Centre
	Shawbow Farag	Catholic Immigration Centre
<b>London</b>	Valerian Marochko	London Cross Cultural Learning Centre
	Mr. Tam Dam	London Cross Cultural Learning Centre
	Jan Jasnos	London Cross Cultural Learning Centre
	Sherin Hussein	London Cross Cultural Learning Centre
	Jennifer Williamson	London Cross Cultural Learning Centre
	Sherri King	London InterCommunity Health Centre
<b>Toronto</b>	Yasmine Dossal	COSTI Immigrant Services
	Colin MacKay	COSTI Reception Centre
	Ahmad Asey	COSTI CSS Manager
	Duncan Eby	Access Alliance Multicultural Health and Community Services

<b>Windsor</b>	<b>Kathleen Thomas</b>	<b>Multicultural Council of Windsor and Essex County</b>
	Marcela Diaz	Multicultural Council of Windsor and Essex County
	Patricia Carter	Multicultural Council of Windsor and Essex County
	Ana Milojevic	Multicultural Council of Windsor and Essex County
	Grace Lasala	Multicultural Council of Windsor and Essex County
	Dr. Ben Kuo	University of Windsor, Department of Psychology
	Dr. Annette Dufresne	Multicultural Council of Windsor and Essex County

## Appendix B: Interview and Roundtable Discussion Guides

### Interview Guide – Reception Centres

#### CIC - Improving Outcomes for GARs in Ontario: Creating Effective Settlement and Health Sector Partnerships and Practices

#### Interview Guide - Ontario Reception Centres

In April 2011, Citizenship and Immigration Canada (CIC) contracted PSTG Consulting Inc. to carry out a project that will help to ***improve health outcomes for Government Assisted Refugees (GARs) in their first year in Ontario***. This project will support the development of service delivery models, tools, frameworks and guidelines for service provider organizations across Ontario. In doing so, we expect to enhance program delivery to GARs across the province so that services are more effective, efficient, comparable, and measureable. In order to understand the current state of health services to GARs in their first year in Ontario PSTG is doing preliminary interviews with all of the reception centres of the Resettlement Assistance Program. These interviews will be followed by interviews with the partners providing health services to GARs, a survey to all stakeholders, and site visits to discuss potential future models. We thank you in advance for your participation and contribution to this project.

Before we get started, we want to clarify that our focus on health includes both physical and mental health.

1. Can you please describe your reception centre?
  - a. Is it a hotel or residence model?
  - b. If it is a residence, are other settlement services provided by your organization at the same location?
  - c. What is the length of stay of the GARs at your reception centre?
    - i. What is the target length of stay?
    - ii. What is the average length of stay?
  - d. Please describe the main roles and responsibilities of the program staff at the reception centre.
2. Please walk us through the process that the reception centre undertakes with the GARs while they are clients of the reception centre. Please highlight the health services.
  - a. Please walk us through the sequence of events/timelines?
  - b. What is done by staff of the reception centre vs. external staff?
3. What health services (if any) are provided on site at the reception centre? Describe
4. What health services are provided off site? Describe

5. What other organizations/individuals does/has your reception centre worked with to provide health services to GARs? Please be specific.
  - a. What services do these organizations provide?
  - b. What organizations/individuals are regular partners and why?
  - c. What organizations/individuals are one off partners and why?
  - d. How did the partnership with these organizations/individuals begin?
6. What do you feel are the greatest barriers facing GARs in terms of health services while they are at the reception centre?
7. Does your organization have any involvement in transitioning the GARs health services when they leave the reception centre?
8. What do you feel are the greatest challenges to GARs accessing health services after they transition from the reception centre?
9. What do you feel are the biggest influences on GARs accessing health services during their first year in Ontario?
  - a. How do they affect the GARs?
    - Probe: Positive effects
    - Negative effects
    - Understanding of the Ontario health system
    - Availability of interpreters
10. Do you have recommendations for best/promising practices for providing health services to GARs at any time during their time at the reception centre?
11. Do you have recommendations for best/promising practices for providing health services to GARs at any time during the first year in Ontario?

## Interview Guide – Health Partners

### CIC - Improving Outcomes for GARs in Ontario: Creating Effective Settlement and Health Sector Partnerships and Practices

#### Draft Interview Guide – Ontario Health Partners

In April 2011, Citizenship and Immigration Canada (CIC) contracted PSTG Consulting Inc. to carry out a project that will help to **improve health outcomes for Government Assisted Refugees (GARs) in their first year in Ontario**. This project will support the development of service delivery models, tools, frameworks and guidelines for service provider organizations across Ontario. In doing so, we expect to enhance program delivery to GARs across the province so that services are more effective, efficient, comparable, and measureable. In order to understand the current state of health services to GARs in their first year in Ontario PSTG is doing preliminary interviews with all of the reception centres of the Resettlement Assistance Program. These interviews will be followed by a survey to all stakeholders and site visits to discuss potential future models. We thank you in advance for your participation and contribution to this project.

Before we get started, we want to clarify that our focus on health includes both physical and mental health.

1. Can you please describe you and your organization's role with GARs? What services do you provide and which staff provides these services?
2. Please walk us through the process that you undertake with the GARs when they first arrive in Canada. Please highlight the health services you provide.
  - a. How do GARs get referred to you/come to you for services?
  - b. What services do you deliver when you first see the GARs? On subsequent visits during the first three weeks? How are these follow up visits coordinated?
  - c. Please describe where you deliver health services.
  - d. Please describe your relationship with Reception Centre or CSS staff, if any.
3. Are you involved with GARs as they transition from the reception centre and move to their first homes?
  - a. If yes, please describe your role, what services you provide and where services are provided. How are these ongoing encounters coordinated/facilitated? Please describe your relationship with the reception centre staff and the CSS workers.
  - b. If no, please provide the reason(s) that you are not involved.
4. How did you first become involved in working with GARs?
5. Has your work with GARs evolved since its onset?
  - a. If yes, please describe this change.

- b. Are you, your organization funded to work with GARs? If so, how?
- 6. Are there other organizations/individuals you work with to provide health services to GARs?  
Please be specific.
  - a. What services do these organizations/individuals provide?
  - b. What organizations/individuals are regular partners and why?
- 7. What do you feel are the greatest barriers facing GARs in terms of health services:
  - a. While they are at the reception centre?
  - b. In transitioning from the reception centre?
  - c. After transitioning, during the remainder of their first year in Ontario?
- 8. What do you feel are the biggest influences on GARs accessing health services during their first year in Ontario?
  - a. How do they affect the GARs?  
 Probe: Positive effects  
  
 Negative effects  
  
 Understanding of the Ontario health system  
  
 Availability of interpreters
- 9. Do you have recommendations for best/promising practices for providing health services to GARs at any time during their first year in Ontario?

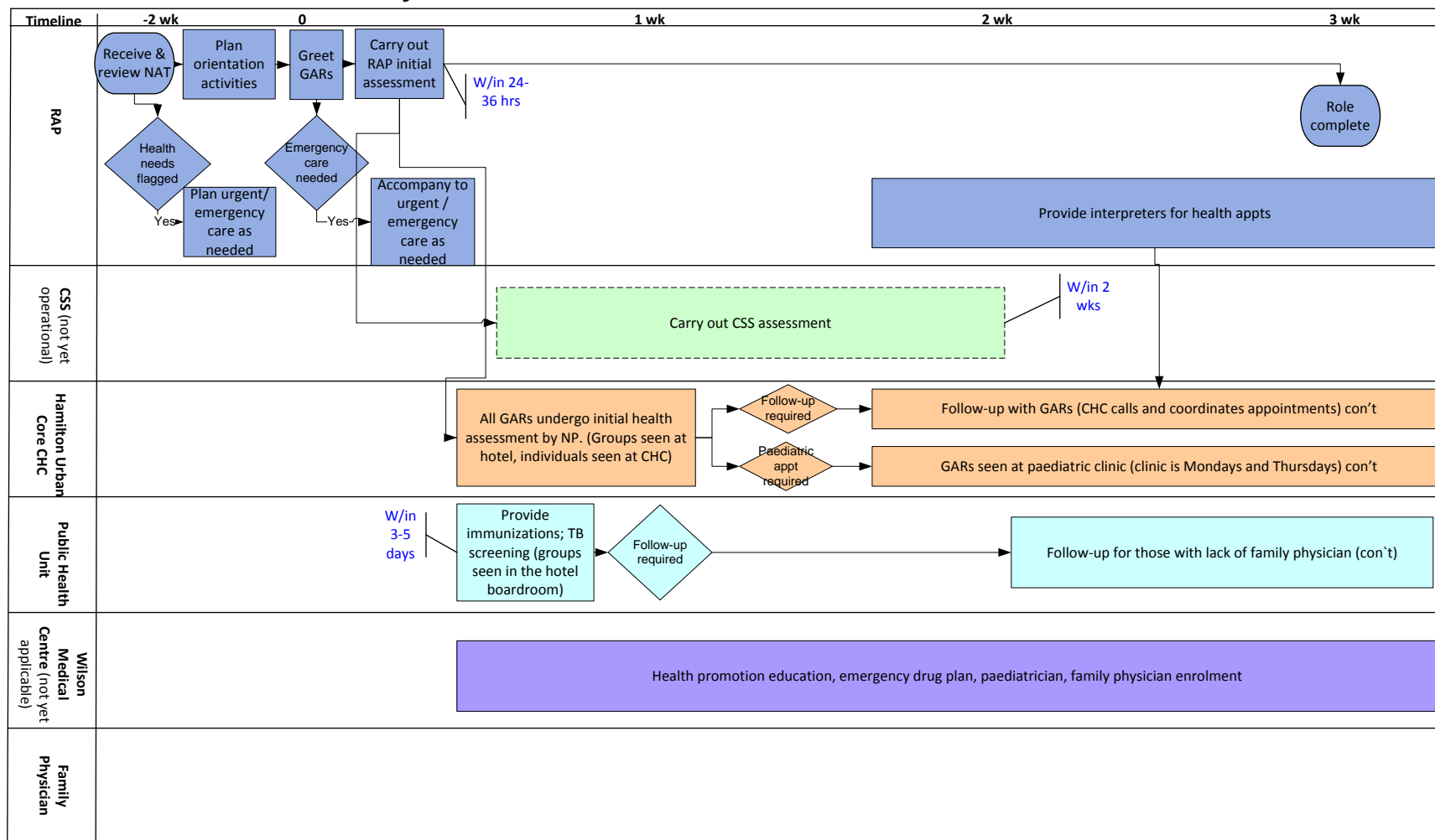
### Roundtable Discussion Guide

- 1. Project update
  - a. Review objectives
  - b. Review activities undertaken to date
  - c. Review timeline and next steps
- 2. Presentation and discussion of preliminary findings
  - a. Challenges
  - b. Promising practices
- 3. Validation of current health service delivery model

- a. Stakeholder relationships and/or map
  - b. Process maps
- 4. Discussion
- 5. Review of next steps

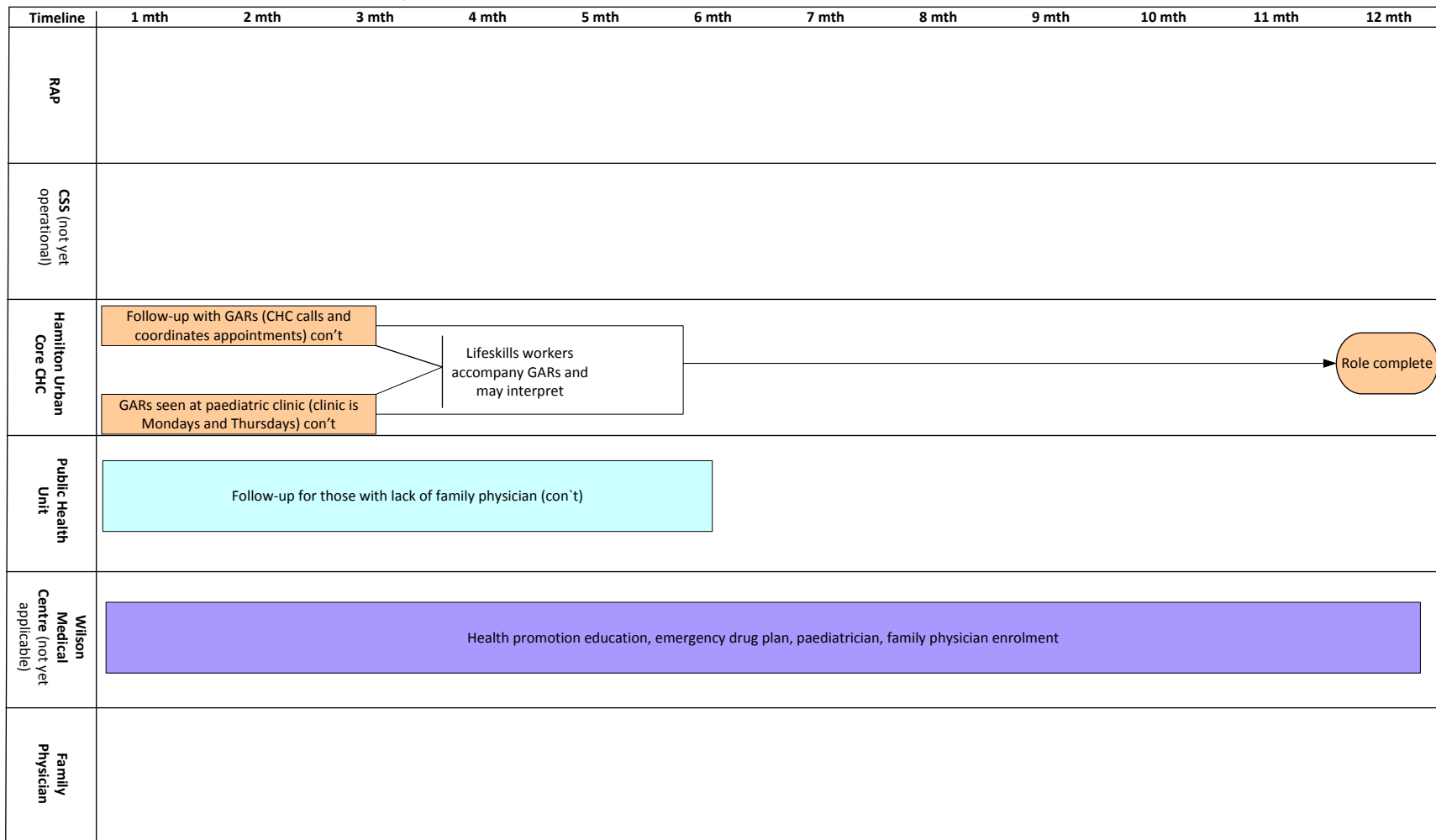
## Appendix C: Site Process Maps

### GARs Service Delivery Process – Hamilton

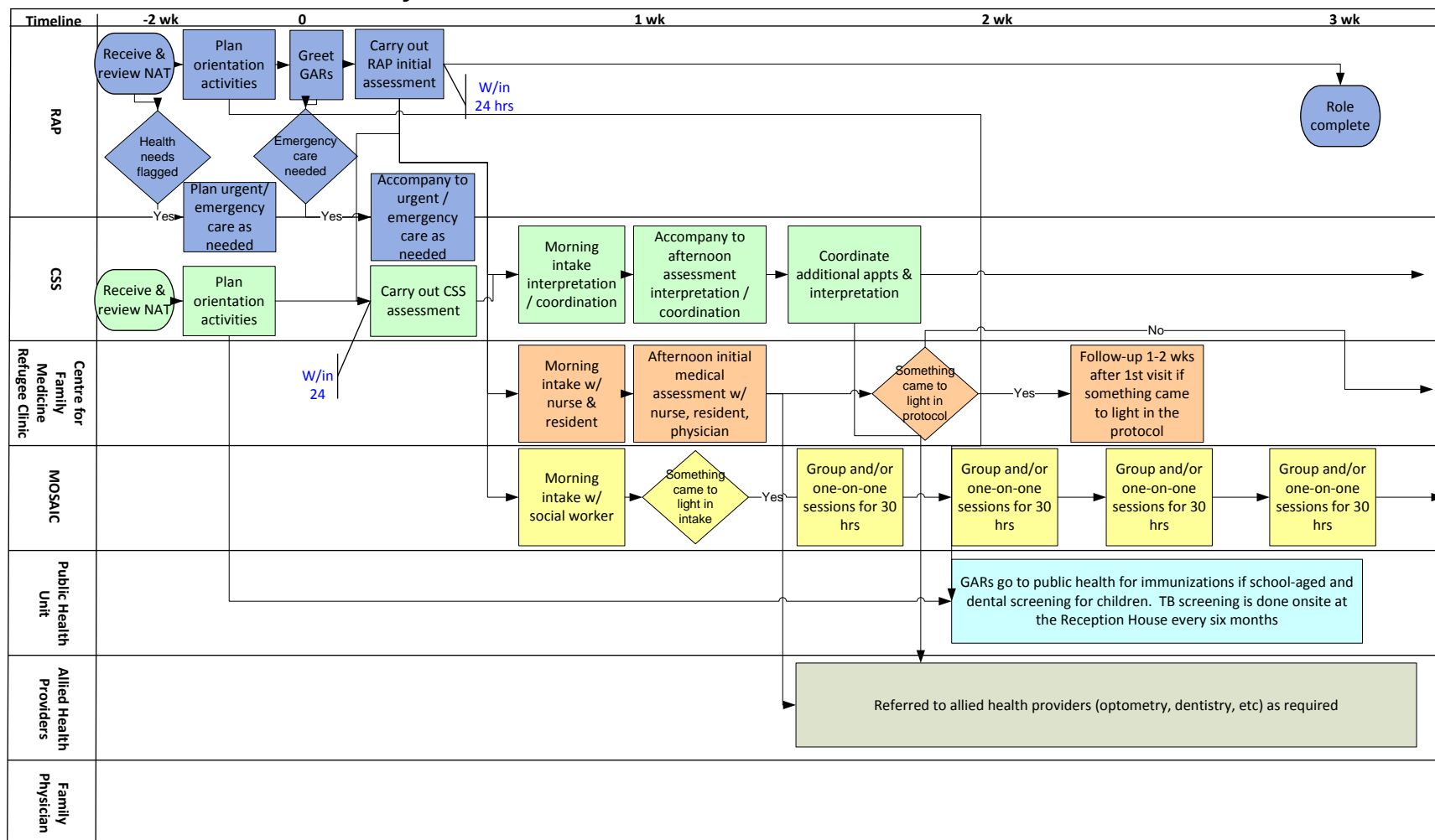




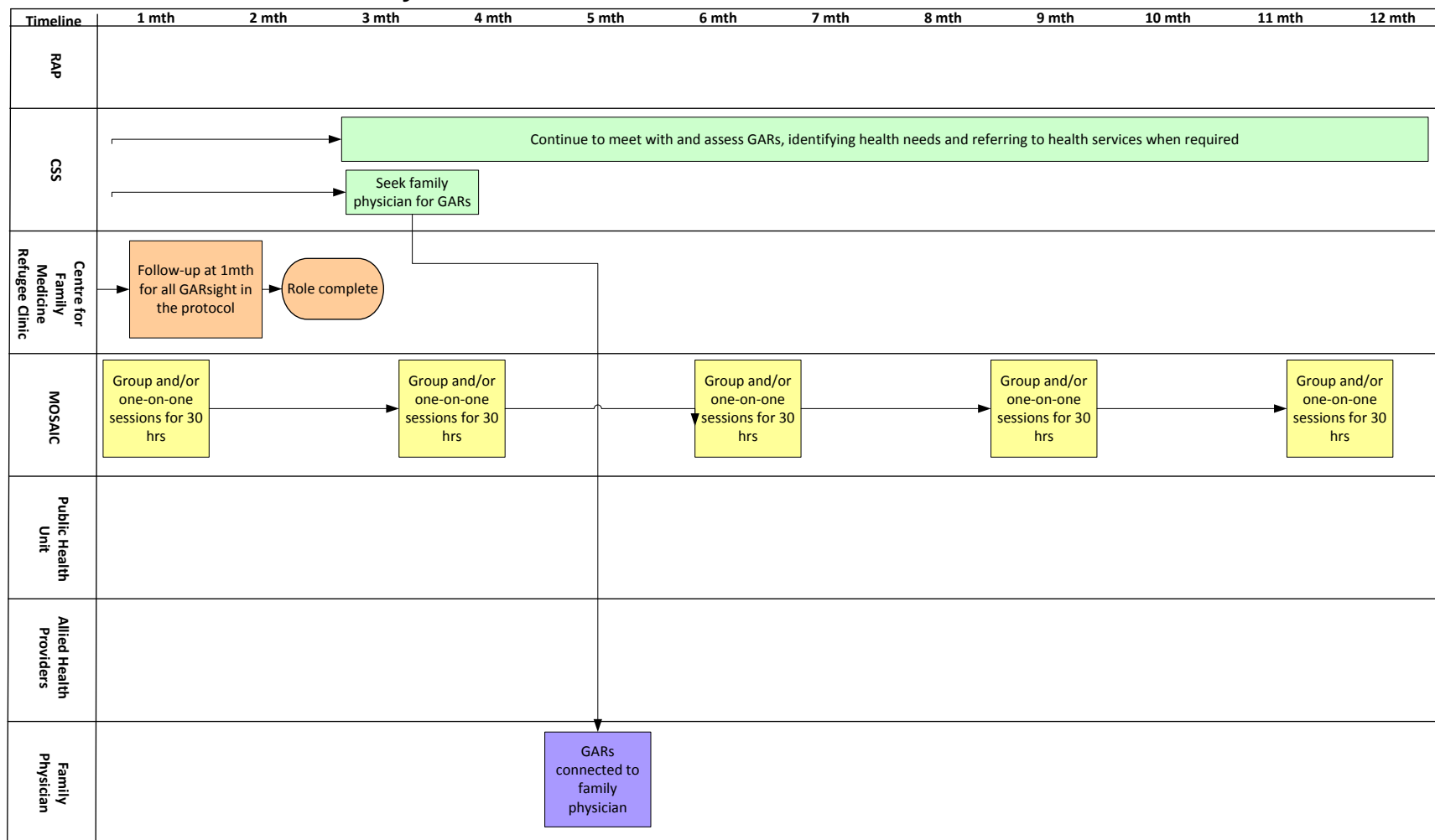
## GARs Service Delivery Process – Hamilton



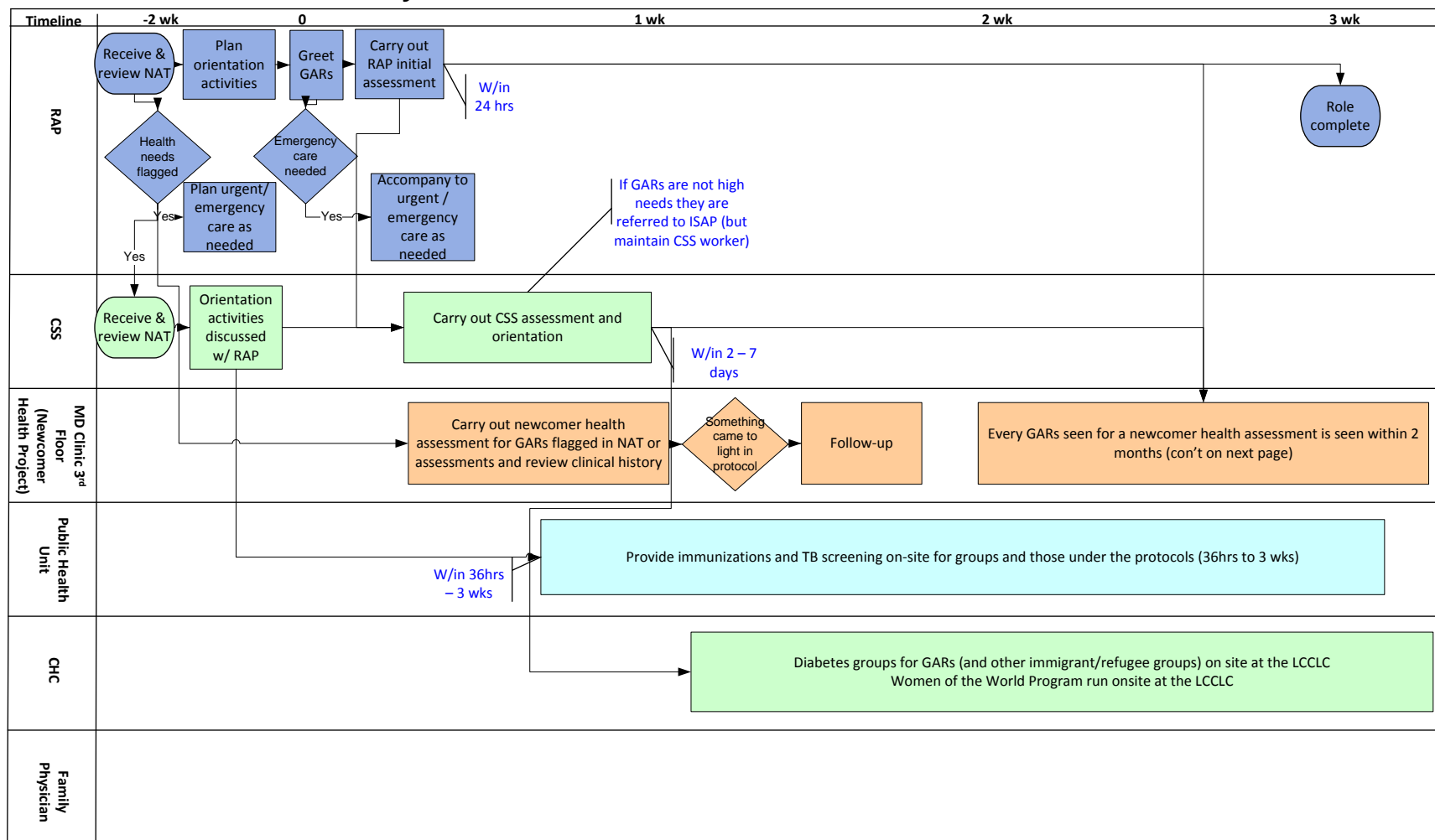
## GARs Service Delivery Process – Kitchener - Waterloo



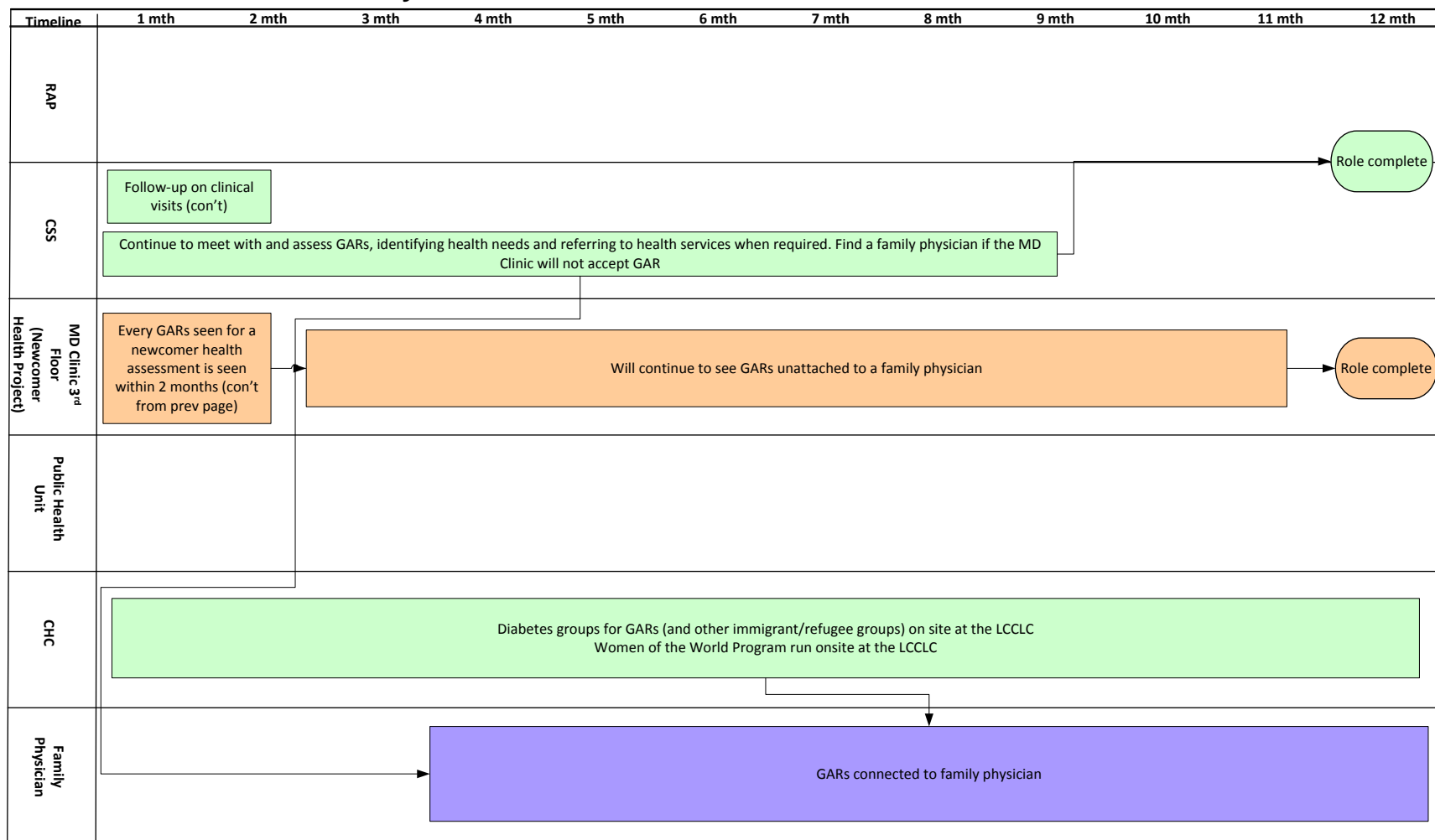
## GARs Service Delivery Process – Kitchener - Waterloo



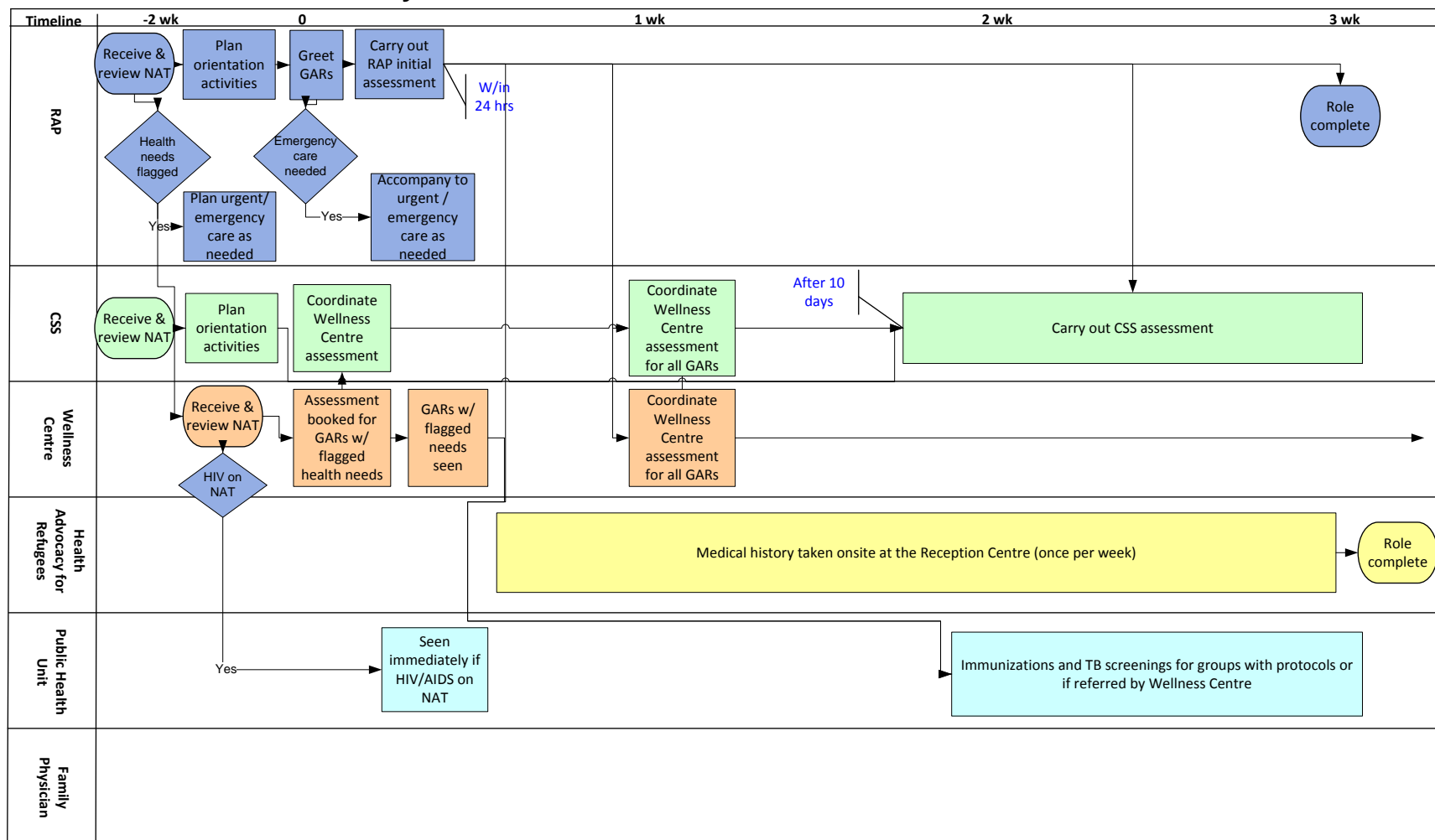
## GARs Service Delivery Process – London



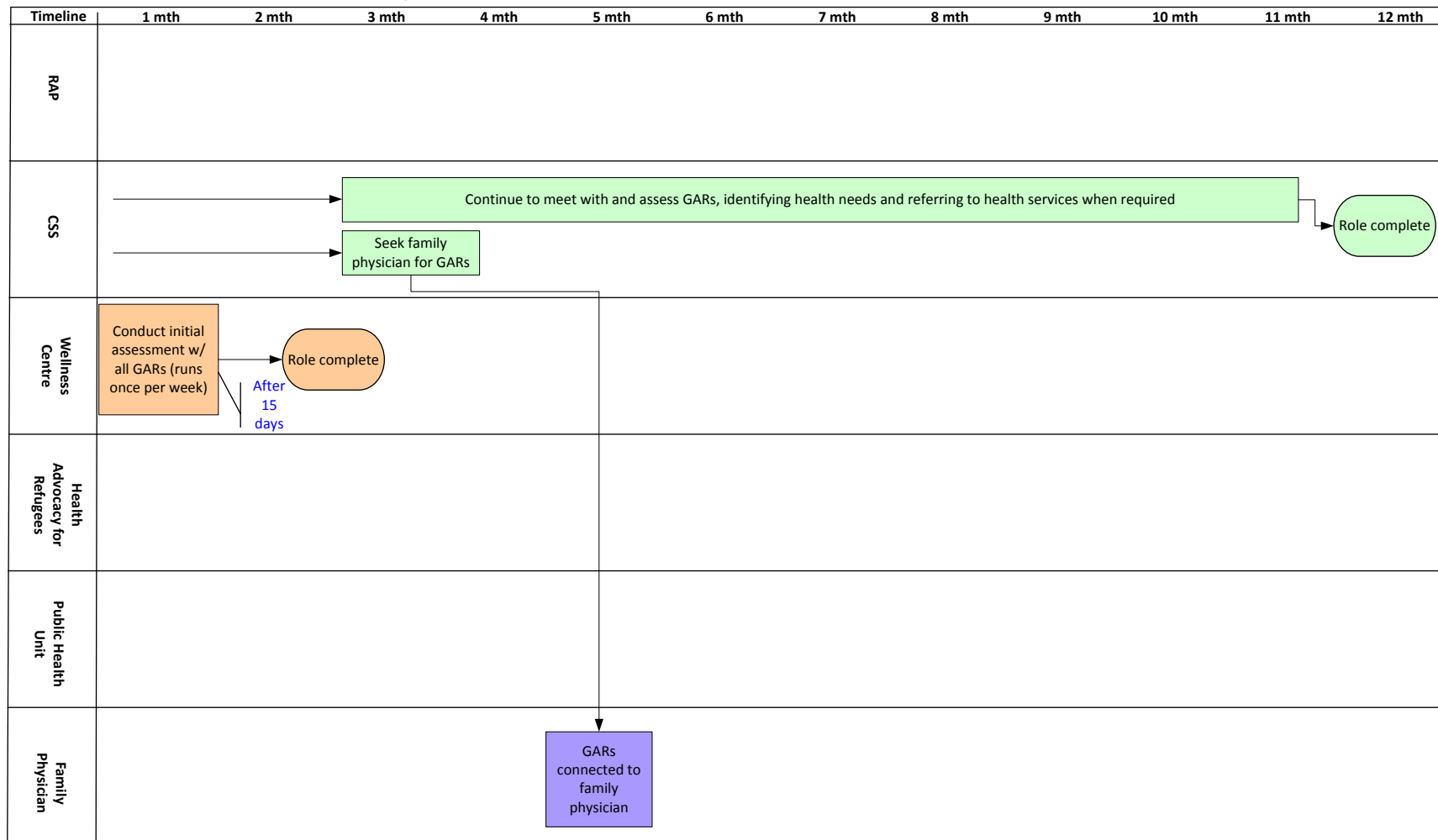
## GARs Service Delivery Process – London



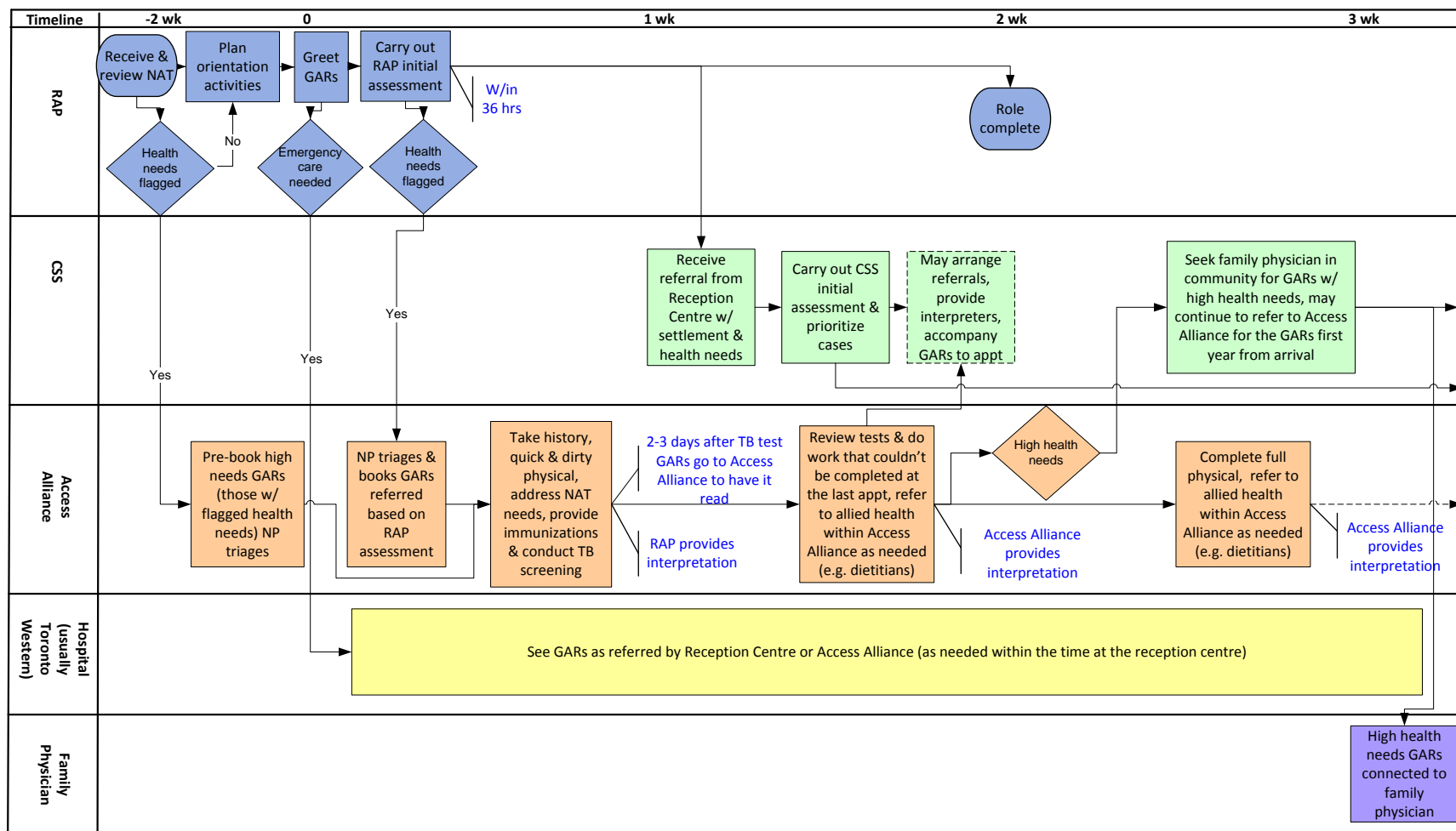
## GARs Service Delivery Process – Ottawa



## GARs Service Delivery Process – Ottawa

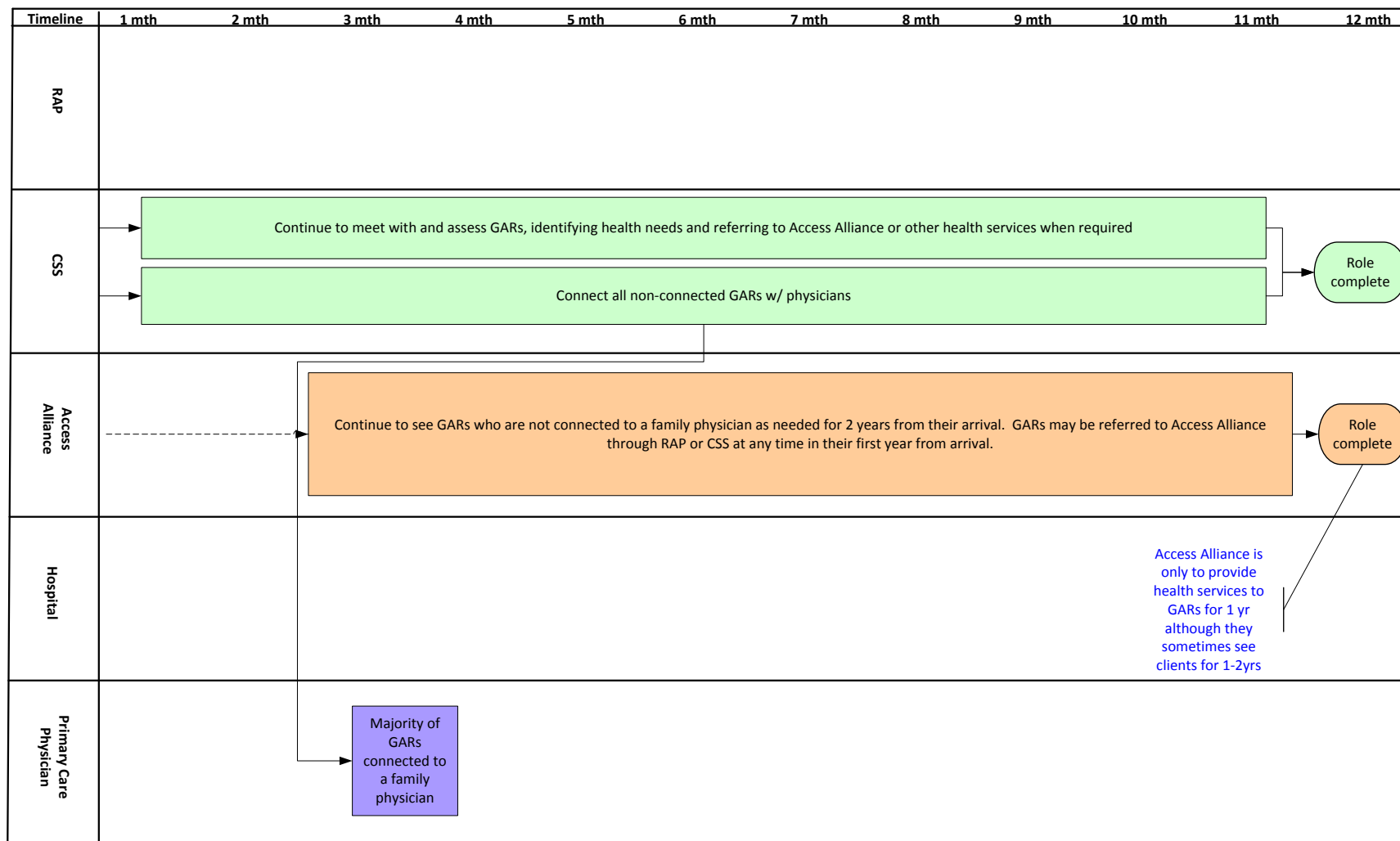


## GARs Service Delivery Process – Toronto

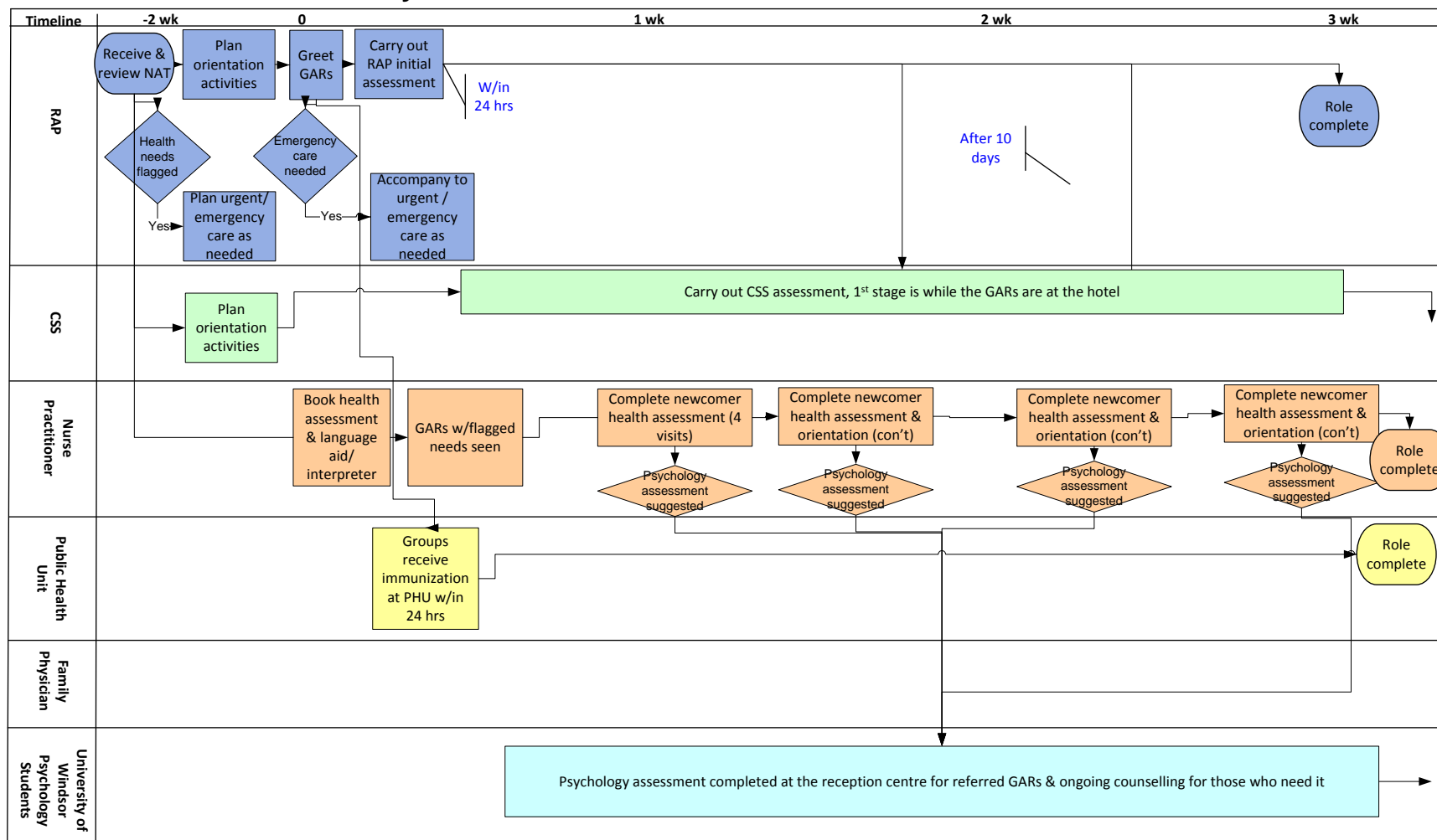




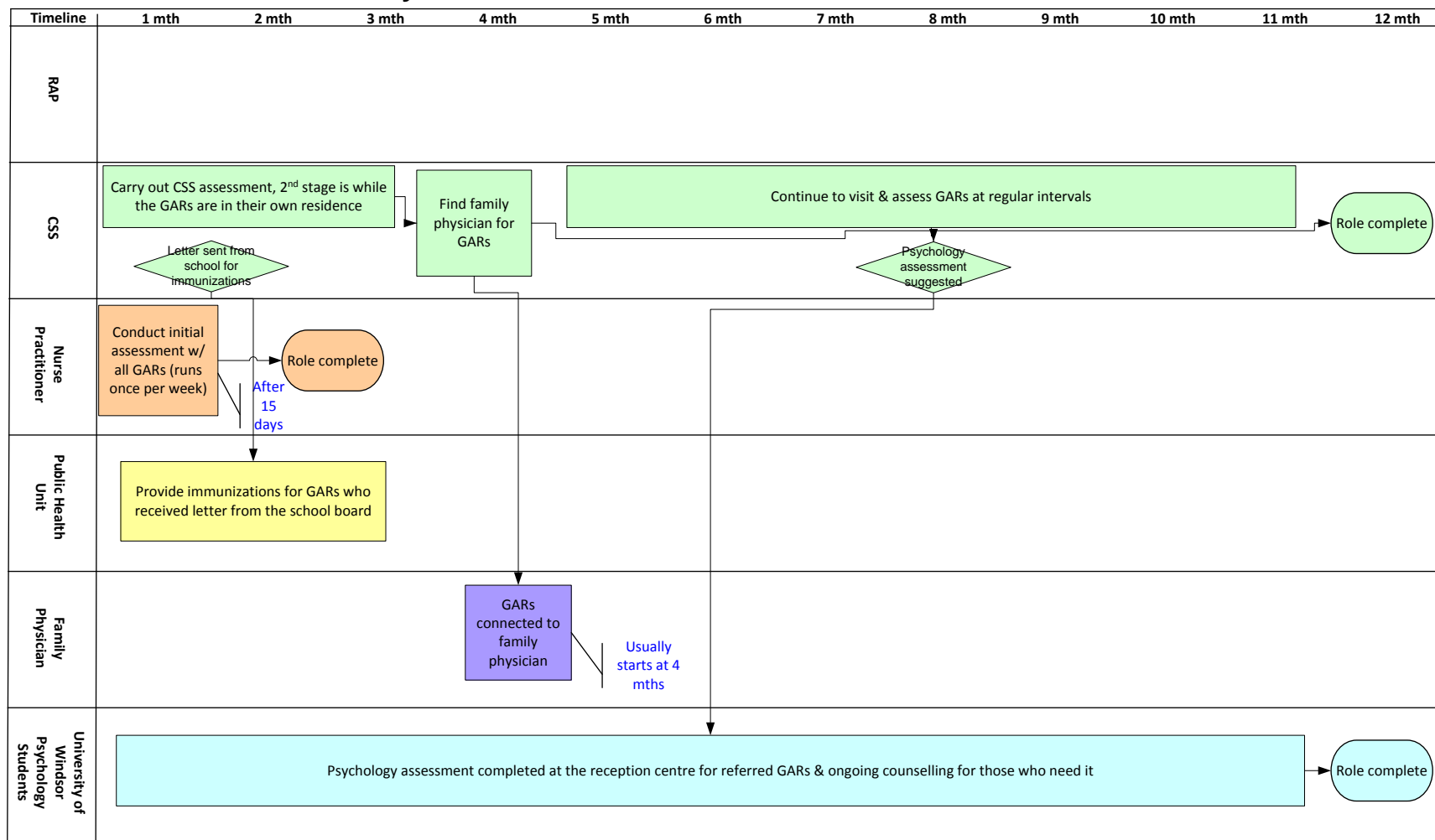
## GARs Service Delivery Process – Toronto



## GARs Service Delivery Process – Windsor



## GARs Service Delivery Process – Windsor



## Appendix D: Glossary

### Terms

Contribution agreements

### Definitions

Contributions agreements are conditional transfer payments to an individual or organization for a specified purpose pursuant to a contribution agreement that is subject to being accounted for and audited. Should the individual or organization use the transfer payment in the manner specified by the contribution agreement, the government does not expect to receive any goods or services directly in return, to be repaid or to receive a financial return.

Health assessment

Health assessment for the purpose of this document is an initial evaluation of the health status of GARs once they have arrived in Ontario. This may range from questions about the current health status of the GARs to a physical examination to a physical examination with lab tests. Also referred to as primary care intake.

Health Service Provider  
Organizations (SPOs)

Health SPOs refer to the SPOs that provide services to GARs. These SPOs may be primary, secondary, tertiary or quaternary health care providers.

Health Service Provider Partners

These are the health service providers, at all levels of health care, that work with the sites or GARs to provide health services to GARs in their first year in Ontario.

Language aids

Language aids are interpreters used by the MCC in Windsor. They have undergone training to provide interpretation services, however, they are not certified.

Medical history

A medical history is information gained by a physician, resident, nurse, or nurse practitioner by asking specific questions, either of the patient or of other people who know the person and can give suitable information, with the aim of obtaining information useful in formulating a diagnosis and providing medical care to the patient.

Partners

Partners are individuals or SPOs that work closely with the sites to provide health services to GARs. These may be either formal or informal partners, meaning they may or may not have agreements to provide the services.

Primary care

Primary care is the term for principal point of health services provided to GARs. They may be provided by a physician, resident, nurse, or nurse practitioner. Depending on the nature of the health condition, patients may then be referred for secondary and/or tertiary care.

Promising practices	These are practices that have proven effective at achieving a specific aim, and hold promise for other organizations. Unlike best practices, however, there may not exist documentation to support the effectiveness of these practices.
Secondary care	Secondary care is the term for health care services provided by medical specialists and other health professionals who generally do not have first contact with patients, for example, physiotherapists, optometrist, dentist, cardiologists, urologists and dermatologists.
Service delivery partnership agreements	These agreements are entered into by two or more organizations and/or individuals for the purpose of providing services. They generally outline the services to be provided, expected outcomes, and reporting expected.
Settlement Service Provider Organizations (SPOs)	For the purpose of this document settlement SPOs refers to the organizations contracted by the CIC to provide RAP and CSS programs and services.
Sites	Sites in this document refers to the six reception centres, and CSS and RAP providing organizations that receive GARs in Ontario.

## **Appendix E: COIA Modernization Priorities**

### **CIC - Ontario Region Settlement Priorities 2011 -12**

#### **Annex A**

##### **Guiding Principles**

CIC Settlement programs aim to facilitate the full participation of newcomers into Canadian society as well as their integration to society that will recognize the contributions of newcomers. Projects and programs that are timely, responsive and cost effective are essential to reaching this objective. To highlight this approach, CIC has set guiding principles for this Call for Proposals. Along with standard operating principles such as inclusiveness and accessibility, applicants should incorporate the following into their project development.

- Responsiveness to client needs
- Place-based initiatives
- Partnership-based approaches
- Value for money
- Achievable milestones
- Project management, including a feasible work plan
- Organizational capacity
- Results measurement

##### **The Priorities**

The past few years of Settlement programming have been shaped by the four key objectives of the Canada Ontario Immigration Agreement

<http://www.cic.gc.ca/english//resources/publications/settlement/coia-plan.asp>. Within the framework of COIA, priorities were identified through consultation, negotiation and discussions with a number of stakeholders. Implementing responses to the identified needs has been central to CIC's settlement strategy. This programming model will continue into the new era of settlement program development.

CIC wishes to acknowledge the work of the Language Training Working Group and the COIA Settlement Working Group on the development of the recommendations related to the COIA objectives and the related priorities. We also wish to acknowledge the collaboration of the Ministry of Citizenship and Immigration (MCI) is setting the strategic directions of this work. The contributions of our partners have provided the framework for the identification of the priorities for future program development outlined in this document. Please note, further priorities may be identified at a later date and addressed by the use of targeted initiatives.

The Ontario Region Call for Proposals seeks the submission of proposals that will support the priorities for CIC's Settlement Program. This document may be used as a tool to assist in the examination of local

priorities and to develop proposals to address identified gaps. **It is not expected that each application will attempt to cover all identified priorities.** As we transition to the full roll-out of the Modernized Approach, CIC encourages organizations to submit proposals based on current successes.

Applicants interested in settlement funding in new areas of business should examine the ability of the organization they represent to address the identified priorities.

**Questions on the Modernized Approach CFP and the need and ability to address the identified regional priorities may be forwarded to [infoCFP2011@cic.gc.ca](mailto:infoCFP2011@cic.gc.ca) prior to May7th 2010. Questions and responses will be posted on the Settlement At Work website. See details on submitting proposals in the CFP guide on [atwork.settlement.org](http://atwork.settlement.org)**

### **CIC - Settlement Priorities by Category**

CIC will consider additional initiatives in the following areas:

- I. To Support programming expansion in Underserved Areas
- II. To Support Specialized Client Services
- III. To Support the implementation of Innovative Service Delivery Models
- IV. To Support the integration of Francophone Newcomers in Minority Francophone Communities
- V. To Support Language and Skills Programs (LINC)
- VI. Research
- VII. Reporting and performance measurement tools/practices and models

#### **I. To Support Underserved Areas**

##### **Foster partnerships and coordination**

- Development of partnerships among service organizations, government, private sector, community organizations and the employment sector to deliver services including the creation of social networks. Some of these new partnerships could
  - Include members of trade unions, volunteers, faith based groups and specialized services organizations to develop services for newcomers

- Foster direct working relationships with employers, to develop services for newcomer employees. An example would be to illustrate benefits to employers of providing services to newcomers ( e.g. higher retention rates)
- Creation of one – stop shops for newcomer Francophone community members based on the current geographic distribution of the Local Francophone Immigration Networks
- Support the development of new settlement programming specifically designed for :
  - Rural and small centres
  - Northern and remote areas,
  - Growing boundary areas (around a metropolis)
  - And high density metropolis neighbourhoods

*\*See Priorities - Annex A for guidance on above population centres*

#### **Develop alternative or distance type learning services**

- Establishment of itinerant services where appropriate
- Development of online (including videoconferencing) and 1 – 800 services to meet additional underserved areas' client needs

#### **Promote Outreach**

- Establishment and expansion of outreach services through a multitude of avenues – including local agencies and organizations

## **II. To Support Specialized Client Services**

#### **Youth Programming**

- Enhancement of newcomer youth awareness of sports and arts oriented opportunities with organizations acting as advocates in areas of access and acceptance
- Pursuance of a broader range of arts oriented programs and partners for newcomer youth
- Development of programs within specialized arts and design schools



- Counseling for newcomer youth, to include assessment, guidance and solution based referrals
- Liaison with mental health services to ensure that counsellors and other professionals are trained and service organizations are equipped to deal with newcomer youth and their families
- Development of specialized youth employment preparation programming with a special focus on networking and work pathways counseling
- Development of outreach programming to connect youth with parents who for whatever reason are not involved in the school system or settlement agencies
- Development of innovative, region-wide service delivery models to serve children and youth in schools

### **Women's Programming**

- Development of employment, employability and training geared towards creating new internship programs, and expanding and promoting existing internship programs to assist newcomer women in achieving employment commensurate with their skills and experience
- Establishment of social supports and networks that encourage and support service providers in providing community-based networking events (i.e. play groups) and programs to help provide social support for women
- Delivery of programming offering financial literacy training initiatives geared specifically at newcomer women
- Offer of emotional well-being and mental health programming that encourages greater awareness and builds capacity within both the mental health and the settlement sectors to address mental health and well being among newcomers through skills building and improved service collaborative between the sectors
- Provision of services addressing domestic violence and increasing awareness among newcomer women about domestic violence and related Canadian laws and women's rights, while ensuring that services are offered through accessible channels for newcomer women
- Development of volunteering/mentorships/internships to enhance greater civic involvement, volunteering and mentorship opportunities for newcomer women and to help newcomer women gain valuable employment experience and build social networks
- Development of programming for newcomer women that include a basic skills component (driving, computers, basic accounting)
- Provision of Housing information and appropriate assistance in accessible and multiple formats

- Also see Language Skills, Research

### **Senior's Programming**

- Development of programs and supports for aging at home, home care services and long term care issues
- Promotion of outreach and communication on safety, security and legal rights
- Development of programs with coordinated solutions and service delivery among organizations, government and community partners
- Development of services for seniors that are family- based, gender targeted and peer base (seniors helping seniors)
- Development of services that address emotional well being and isolation – services that address more than mental health concerns
- Development of Alternative service delivery models – programs that include itinerant services and may target neighbourhood congregation places, such as places of worship
- Also see Language Skills, Research

### **Services for Persons Living with Disabilities**

- Development of programs and supports with a focus on partnerships with other community agencies and services that assist in meeting the needs of newcomers living with disabilities
- Outreach programming – awareness initiatives and communication with newcomers living with disabilities
- Development of specialized services for persons living with disabilities, with a focus on employment, health and social networks development and other identified needs

### **Mental Health Programming**

- Development of partnerships with other community agencies and/or government services that provide mental health programs with a goal of enhancing services for newcomers and specifically Government Assisted Refugees and Privately Sponsored Refugees
- Development of newcomer awareness to mental health issues
- Building capacity and encourage partnership between the mental health and settlement sector
- Programming that explores non medical models of mental health support and partnership

### III. To Support Innovative Service Delivery Models

#### **Within Welcoming Communities - Community Connections:**

- **Fostering Engagement between Newcomers and Canadians:** Engagement projects that seek to involve newcomers directly in the community, such as through mentorships, sports and recreational activities, community groups, participation on school boards or councils, etc.
- **Creating Welcoming Spaces and Communities:** to promote the development of a welcoming community and effectively engage newcomers, CIC encourages proposals to co-locate settlement services, such as in an information centre or a neighbourhood house. In order to increase accessibility, CIC also encourages proposals to incorporate activities that maximize public community spaces, such as a community centre or mall, in innovative ways
- **Raising Awareness and Understanding:** Awareness raising activities utilize new or existing resources to increase public awareness, understanding and dialogue among targeted groups or the community as a whole on issues related to immigrant settlement and integration. Topics may include rights and responsibilities, racism and discrimination, the unique contributions of newcomers to Canada, or other issues identified by the community
- **Planning, Promotion and Partnerships:** Planning and partnership projects bring together diverse organizations and agencies to coordinate their efforts on initiatives to welcome immigrants destined to their community. Partners should work together to establish a common vision around fostering welcoming communities and supporting integration. Promotion projects focus on the promotion of settlement services and seek to increase uptake by newcomer clients while also encouraging greater volunteer involvement from community members
- **Capacity Building:** Capacity building projects should promote learning and knowledge sharing in the settlement sector and the community at large in order to better understand newcomer needs and effectively contribute to settlement and integration

#### IV. To Support Immigration of Francophone Newcomers in Minority Francophone Communities

In addition to meeting the needs of services in French, CIC Ontario Region has outlined the following priorities in the Official Languages portfolio:

- Development of recruitment strategies of skilled workers and students with the goal of increasing the percentage of francophone immigrants in francophone minority communities
- Development of new initiatives supporting the economic integration of francophone immigrants
- Innovative projects focusing on the creation of social partnerships targeting Francophone women, seniors and youth
- Development of new programming supporting the needs of Francophone refugees
- Development of alternative service delivery models for language training and skills development targeting Francophone immigrants

#### V. To Support Language and Skills Programs (LINC)

##### Seniors - LINC classes for Seniors

- Provision of language programming for older adults including: LINC classes in locations where seniors can access other settlement services
- Development of specialized curriculum (i.e. helping new newcomers to learn to tell a doctor what is ailing them, etc.), and learning how to speak “survival”, or “functional” English in tailored classes
- Development of teaching materials that take into account the special needs of older learners including the use of large print material
- Development of small bilingual classes for seniors, particularly at lower-level and literacy classes. *It is recognized that a bilingual class may not be possible in areas where the seniors’ population is smaller and more heterogeneous*
- Provision of assistants, interpreters, itinerant teachers or specialized volunteers for one-on-one and small group support in senior classes
- Delivery of focused non-multi level classes
- Development of performance outcomes measurement for older adults and related “senior-friendly”. student evaluation and assessment

##### Language in the Workplace

- Development of language training programming that assists newcomers to obtain employment and improve the ability to communicate effectively in the workplace. Through the Enhanced

Language Training initiative, Occupation Specific Language Training, and regular LINC programming, CIC funds language training for the workplace. CIC is considering funding 'in the workplace' programming provided that the programming includes general settlement themes.

- Language training “*In*” the workplace refers to language training that helps employees maintain employment and improve their communication skills in their workplace. Although it need not necessarily take place at the work site, Service Providing Organizations should work closely with employers in order to develop appropriate course content
- Exploration of the possible need for language training programs for newcomer women at lower CLB levels, with a workplace focus

VI. **Research**

- Academic or community based research on topics related to settlement in Ontario

VII. **Reporting and performance measurement tools/practices and models**

- Development of tools, practices and models that may be used to enhance knowledge and improve the delivery of services in the settlement field

**Please note: Proposals must indicate whether they are regional or local in scope and meet an identified need, and specific priority**

**\*ANNEX A - TYPES OF UNDER-SERVICED AREAS – SETTLEMENT WORKING GROUP**

**NORTHERN AND REMOTE** (e.g., Sudbury, Deep River)

**Population Characteristics**

- Low numbers of newcomers, dispersed over a large geographic area
- Skilled newcomers move to northern/remote areas primarily because a) they have acquired a job or b) they are attending university (and thus, leave when their degree is completed).
- Consistent out-migration of population, especially youth
- High proportion of Aboriginal population (compared to other areas on Ontario)
- Some clusters of Francophones but limited Francophone services
- Pockets of older immigrants in some centres

**Geographic Characteristics**

- No or few major cities
- Severe transportation limitations but main roads links are good
- Distance and weather issues restrict access and mobility

**MEDIUM-SIZED CITY** (e.g., Hamilton, Ottawa)

### **Population Characteristics**

- Sections of rapid and significant population growth
- Population density varies (from low to high) ; includes some rural areas and small centres (e.g. where a recent Ontario municipal amalgamation has included rural sections)
- High density areas are likely to be clustered
- High density areas are characterized by young families and a large youth population; thus schools have significant numbers of newcomers
- Clusters of immigrants may encourage dependence/self-reliance within their community (and discourage integration)
- May be a high number of vulnerable refugees

### **Geographic Characteristics**

- Extensive and well-used transportation links (good roads and public transportation system)
- Public transportation is generally accessible except in some fringe areas
- Heavy reliance on private transportation
- Growing number of employment opportunities
- Variation in income (geographic patterns emerge)
- High proportion of population lives in rental housing

## **HIGH DENSITY METROPOLIS NEIGHBOURHOOD**

### **Population Characteristics**

- Population density varies from one neighbourhood to another
- High density areas are likely to be clustered
- May be a high number of vulnerable refugees

### **Geographic Characteristics**

- Settlement occurs across the city with some geographic clustering of newcomers
- Clusters of immigrants may encourage dependence/self-reliance within their community (and discourage integration)
- Public transportation is generally accessible except in some fringe areas

## **GROWING BOUNDARY AREA (AROUND A METROPOLIS) (e.g., Peel Region)**

### **Population Characteristics**

- Rapid and significant population growth
- Widespread population with some high density pockets
- Ethnic community clustering
- Characterized by young families and a large youth population; thus significant number of newcomers in schools
- Profile of immigrant class (to be identified)

### **Geographic Characteristics**

- Often newcomers land and establish themselves in Toronto and then move to the boundary areas although this may be changing (more newcomers may be moving directly to boundary areas)
- Extensive and well-used transportation links (good roads and public transportation system)
- Heavy reliance on private transportation
- Constant traffic patterns

#### **RURAL AREAS AND SMALL CENTRES (e.g., St. Mary's, Chatham)**

##### **Population Characteristics**

- Low numbers of newcomers, dispersed over a large geographic area
- Low population density
- Low concentration of ethnic groups, leading to cultural isolation
- Consistent out-migration of population, especially youth

##### **Geographic Characteristics**

- No major city nearby; within driving distance of a small- or medium-size centre
- Limited public transportation

## Appendix F: MOHLTC Priorities

### MOHLTC Strategic Directions

1. Renewed community engagement and partnership in and about the health care system;
2. Improve the health status of Ontarians;
3. Ontarians will have equitable access to the care and services they need no matter where they live or their social, cultural and/or economic status;
4. Improve the quality of health outcomes; and
5. Establish a framework for sustainability of the health system that achieves the best results for consumers and the community

### MOHLTC Strategic Priorities

1. Reducing wait times in emergency departments
2. Reducing the time patients spend in alternate level of care beds in hospitals
3. Improving access to integrated diabetes care



## Appendix G: Public Health Priorities

The programs of public health are directed at the following areas of focus:

- Health promotion and wellness
- Family health
- Chronic disease prevention
- Injury and substance abuse prevention
- Environmental health
- Infectious diseases
- Health surveillance

## Appendix H: Provincial Workshop Participants

Site	Participant Name	Organization Name	Role
<b>Hamilton</b>	Jenney Josipovic	Wesley Urban Ministries	CSS Manager
	Rugiya Mohamud	Wesley Urban Ministries	RAP Settlement Worker
	Janette Godwin	Wesley Urban Ministries	RAP Life Skills Worker
	Ahmed Mohammed	Wesley Urban Ministries	RAP Program Manager
<b>Kitchener-Waterloo</b>	Mira Malidzanovic	Reception House Waterloo Region	Program Director (RAP, CSS)
	Mary Mueller	Region of Waterloo Public Health	Reproductive Health Program
	Glenna Murray	Region of Waterloo Public Health	Public Health Nurse
	Lynne Griffiths-Fulton	Reception House Waterloo Region	CSS (Coordinator, Kitchener site)
	Ruth-Anne McLeod	Region of Waterloo Public Health	Public Health Nurse
	Santiago Grande	Mosaic Counselling and Family Services	Project Coordinator
<b>London</b>	Jennifer Williamson	Cross Cultural Learner Centre	CSS
	Sherin Hussien	London Cross Cultural Learner Centre	CSS
	Dam Tam	London Cross Cultural Learner Centre	RAP Manager
	Emily Htoo	London Cross Cultural Learner Centre	RAP - Settlement Worker
<b>Ottawa</b>	Megan Williams	The Wellness Centre at Centre for Catholic Immigrants Ottawa	Medical Director
	Nadia Youssef	The Wellness Centre at Centre for Catholic Immigrants Ottawa/ Somerset West Community Health Centre	Clinical Coordinator
	Chamrouen Lay	Catholic Centre for Immigrants - Reception House	Manager of Reception House
	Lucila Cabrera	Catholic Centre for Immigrants	CSS Program Coordinator
	Shawbow Farag	Catholic Centre for Immigrants	CSS and Health Support Counsellor
	Ghassan Arabieh	Catholic Centre for Immigrants	Mental Health Support Counsellor
	Paula Day	Somerset West CHC (Wellness Centre)	Health Partner
	Carmen Urbina	Ottawa Community Immigrant Services Organization	Clinical Supervisor - Counselling Program
<b>Toronto</b>	Duncan Eby	Access Alliance Multicultural Health and Community Services	Nurse Practitioner

	Cliff Ledwos	Access Alliance Multicultural Health and Community Services	Health Partner
	Mary Pam Vincer	COSTI Immigrant Services	CSS Assistant Manager
	Yasmine Dossal	COSTI Immigrant Services	Director of Social Services
	Colin Mackay	COSTI Immigrant Services	General Manager
	Mary Gharwal	COSTI Immigrant Services	RAP (Program Liaison)
	Amanda McIntyre	Access Alliance Multicultural Health and Community Services	Registered Nurse
<b>Windsor</b>	Grace Rosete-Lasala	Multicultural Council of Windsor and Essex County	Nurse Practitioner
	Ana Milojevic	Multicultural Council of Windsor and Essex County	CSS Case Manager
	Marcela Diaz	Multicultural Council of Windsor and Essex County	CSS Program Manager
<b>CIC</b>	Christine Charbonneau	Citizenship and Immigration Canada, Ontario Region	Regional Program Advisor
	Fiona Corbin	Citizenship and Immigration Canada, Ontario Region	Regional Program Advisor, Settlement and Intergovernmental Affairs Directorate
<b>YMCA</b>	Katarina Canic	YMCA of Greater Toronto	Manager, Client Support Services Program

## Appendix I: Provincial Workshop Agenda

### CIC-GARs Provincial Workshop Agenda

**Monday, November 28, 2011**

<b>Time</b>	<b>Agenda Item</b>
11:00 – 11:10	Welcome and Introductions
11:10 – 11:30	Warm Up Activity
11:30 – 12:00	Review Workshop Objectives
12:00 – 1:00	<i>Lunch</i>
1:00 – 1:45	Review and Discussion of Project Findings
1:45 – 2:30	Review and Discussion of Options for Improvement
2:30 – 2:45	<i>Break</i>
2:45 – 3:15	Identify Decision Making Criteria
3:15 – 4:45	Action Planning Part 1: Prioritize Options
4:45 – 5:00	Wrap-up and Preparation for Tuesday

## CIC-GARs Provincial Workshop Agenda

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**Tuesday, November 29, 2011**

<b>Time</b>	<b>Agenda Item</b>
8:30 – 9:00	<i>Breakfast</i>
9:00 – 9:30	Warm Up: Review and Validate Prioritized Options
<b>9:30 – 10:30</b>	<b>Action Planning Part 2: Develop a SMART Implementation Plan</b>
10:30 – 10:45	<i>Break</i>
10:45 – 12:00	Action Planning Part 2: Develop a SMART Implementation Plan
12:00 – 1:00	Lunch
1:00 – 2:15	Present and Review SMART Implementation Plan
2:15 – 2:30	Break
2:15 – 3:30	Action Planning Part 3: Validate Overall Implementation Plan
3:30 – 3:45	Summary of the Day
3:45 – 4:00	Thank You, Wrap-up, and Next Steps

## Appendix J: Notes from Provincial Workshop

### Decision-Making Criteria Developed

1. Sufficient and sustainable resources to enable implementation of the option (efficient)
2. Buy-in (local, community, provincial, and federal)
3. Option will promote a standard
4. Measureable positive outcomes (with a SMART objective) - effective
5. Responsive to or client-centred (about the client, not the provider)
6. Foster improved and more formalized community partnerships
7. Increase capacity of service providers
7. Evidence informed
8. Takes into account the broader social determinants of health and all the services involved in them
8. Consider the risks and benefits of the option

### Options for Improvement and Activities to Implement Them as Defined by Provincial Workshop Participants

Options for Improvement	Activities
<b>Develop a local response that that is aligned with the provincial standards and targets while still responsive and reflective of its unique community profile and needs</b>	Support and have input into the development of provincial standards <ul style="list-style-type: none"> <li>- At the annual CSS conference in January 2012</li> <li>- Receive CIC standards that have been developed prior to Jan 2013 annual conference so we can discuss with local teams</li> </ul>
	Once provincial standards have been created do the following: <ul style="list-style-type: none"> <li>- Site specific needs assessment and chart audit</li> <li>- Then fill in gaps</li> <li>- Educate staff as to what are standards and expectations</li> <li>- Community forum to engage community for input into standards – ongoing)</li> </ul>
	Develop local response based on standards and targets that are clearly defined and realistic
	Develop a phased-in timeline and process for sites to align with new standards
<b>Develop a collaborative and interdisciplinary primary care model</b>	Identify key people at sites to initiate model <ul style="list-style-type: none"> <li>- Managers</li> <li>- People who have influence</li> <li>- Resources / staff</li> <li>- Identify key person / coordinator at medical school / partner agency to do scheduling and evaluation</li> </ul>

	<p>Identify key health service provider partners</p> <ul style="list-style-type: none"> <li>- Community health centre</li> <li>- Family health team</li> <li>- University students</li> <li>- Public health</li> <li>- Settlement agencies</li> <li>- Mental health, CMHA</li> <li>- Counselling – private/public, social workers, doctors</li> <li>- Pharmacy</li> <li>- CNIB</li> <li>- Optometrist</li> </ul>
	<p>Engage partners</p> <ul style="list-style-type: none"> <li>- Use NPs to coordinate/deliver primary care services</li> <li>- Leverage medical residents to deliver primary care</li> <li>- Formalize partnerships with local resources such as hospitals, community health centres and public health</li> </ul>
	<p>Nurture partnerships</p> <ul style="list-style-type: none"> <li>- Regular meetings, day , time, location</li> <li>- Ongoing/regular (electronic meetings/province wide meetings/refugee health conference) meetings to share best practices and resources – electronic resources</li> </ul>
<b>Pursue funding and advocate with the MOH/LHIN to fund primary care services for GARs</b>	<p>Forward information from this process to MOHLTC/LHIN to clarify health needs of GARs</p>
	<p>Sites who have been successful in getting money from LHIN provide description of arrangement to other sites</p> <ul style="list-style-type: none"> <li>- What has worked, what has not worked</li> </ul>
	<p>Identify key people/community expertise MOHLTC/LHIN</p> <ul style="list-style-type: none"> <li>- Gather information locally/LHIN/provincial/national</li> <li>- Stats, IFS, budgets, staff</li> <li>- Partnership with health partners</li> <li>- Support it with evidence based</li> <li>- Make a case for further need</li> </ul>
	<p>Advocacy</p> <ul style="list-style-type: none"> <li>- Once gathered all inform Local LHIN/GARs Health Network meet with to advocate for resources</li> </ul>
	<p>Develop arms length advocacy group – ex GARs, professional health associations, faith based organizations to continue ongoing advocacy</p>
	<p>Develop a strategic plan for advocate for increasing funding from MOHLTC</p> <ul style="list-style-type: none"> <li>- Identify clear needs to be presented by next provincial budget review <ul style="list-style-type: none"> <li>o Link to provincial standards/guidelines (to be developed)</li> </ul> </li> </ul>
	<p>Develop and submit a common report to MOHLTC/LHIN</p> <ul style="list-style-type: none"> <li>- Set up a meeting with MOHLTC/LHIN CEO</li> <li>- End result is money embedded in local budgets, target core money</li> </ul>

<b>Develop a mental health response that is aligned with service delivery standards and targets but which is responsive to unique community needs</b>	Draw upon existing promising practices to develop local mental health services for GARs <ul style="list-style-type: none"> <li>- Engage/consult/utilize GAR communities to understand how they understand mental health services.</li> </ul>
	Meeting of local stakeholders: universities, academics, mental health professional, CSS, health providers to identify local capacity. <ul style="list-style-type: none"> <li>- Focus on mental wellness, healthy relationship (with each GAR family, adults, and youth) standards in Canada/strategies/local services</li> </ul>
	Leverage experts and partner with experts in the community to deliver mental health services
	Training various staff group about their role in mental health assessment and use technology to access local resources
	Implement a mental health screening in tool (mental health screening is not recommended for each client) at different stages in the first year post-arrival (i.e. 3 mth, 6 mth) <ul style="list-style-type: none"> <li>- Use observation and subjective data</li> <li>- Develop partnerships (formal/informal) with mental health service providers for client referrals and ethno-specific associations/community</li> </ul>
	Identify a research/coordinator within or outside agency (assume we have money and capacity)
<b>Enhance orientation to and education about mental health for GARs</b>	Suggest CIC expand cultural profiles to include specifics on mental health beliefs/practices of GARs
	"Cultural profiles" from CIC to be distributed to health delivery partners
	CIC should provide / develop a manual and education program (CMHA manual is to be available 2012-2013) <ul style="list-style-type: none"> <li>- Training is not for intervention – refer to local services capacity of community to respond</li> </ul>
	Providing education to CSS/RAP on recognizing mental health requiring intervention
	Ongoing professional development for staff/clinical supervision <ul style="list-style-type: none"> <li>- Resources available for staff</li> <li>- Support / debriefing</li> </ul>
	Develop a peer support program regarding mental health and wellness
	Using community based research to inform/develop education programs for specific cultural groups in addition to North American definitions
<b>Recognize and integrate immunizations as a component of the GARs health service delivery</b>	Include immunizations as a part of the primary care intake/health assessment
	Formal partnership agreement signed with public health for each site
	Each site to develop clear policy and procedure for immunization



<b>model</b>	where/when/who include education for GARs on “why”
	Initiate immunizations while GARS are on site at the reception
	Have the health unit reconcile the immunization record according to the Ontario standards
	Ensure catch-up immunization is initiated in school aged children while at the reception centre according to community resources (PHU, etc)
<b>Involve all health service delivery partners in the planning process</b>	Identify health service delivery partners <ul style="list-style-type: none"> <li>- Managers of key primary care provider, settlement agency, responsible to invite partners (once primary care partner has been identified)</li> <li>- Initiated by managers at site</li> <li>- Network (local) should be included, GARs focused</li> </ul>
	With partners identify objectives of service provision -> determine performance metrics and monitoring
	Establish regular planning meetings at management level <ul style="list-style-type: none"> <li>- One overall annual planning with two follow-up sessions</li> </ul>
<b>Recognize and integrate TB screening as a component of the GARs health service delivery model</b>	Include TB screening a part of the primary care intake/health assessment
	Undertake TB screening in conjunction with health history /other test / immunizations (see above for activities)
<b>Develop and nurture a strong network of allied providers that are practicing in close proximity or that will delivery services in the community (at the reception centres and/or GARS health service delivery sites)</b>	Support providers to register with IFH <ul style="list-style-type: none"> <li>- Identify needs of GARS that allied providers could fill</li> <li>- Identify key players associations of community providers (i.e. dental association, pharmacist association, etc) and present at a meeting</li> </ul>
	Advocate that each new family physician to take five GARs families each year
	CSS manager/staff/organizations build partnership with wellness health promotion, preventive services, e.g. dental hygiene
	Recognize partners on a annual basis
<b>Develop a program of research and disseminate knowledge regarding refugee health</b>	Publish and distribute health profiles for refugee groups
	Present at conferences such as Metropolis and the Refugee Health Conference and actively participate in development of the Refugee Health Conference
	Use existing websites (municipal, CIC, settlement) to distribute info for public, GARs on research
	Connect with research bodies (CCR, metropolis, academic institutions, Inscan, settlement.org) and use world refugee day to promote discourse
<b>Identify experts in global health at local universities and among SPOs and engage experts to:</b> <ul style="list-style-type: none"> <li>- Participate in health service delivery</li> <li>- Undertake global</li> </ul>	Sites to form working groups to connect with experts, yearly and work with LIPs twice per year
	CSS staff/RAP staff deliver presentation to university students / community on issues around refugee health twice per year <ul style="list-style-type: none"> <li>- Social work</li> </ul>

<p><b>health education, research</b></p> <ul style="list-style-type: none"> <li>- <b>Support advocacy with policy makers and funding</b></li> <li>- <b>Network with other global health experts to build a strong network of GARs service providers</b></li> </ul>	<ul style="list-style-type: none"> <li>- Medical programs</li> <li>- Pharmacy</li> <li>- Dental</li> <li>- Nursing</li> <li>- Mid-wifery</li> <li>- Psychology</li> <li>- Optometry</li> </ul>
<p><b>Carry out awareness raising activities in the community to promote sensitivity and awareness regarding GARs issues in the broader community</b></p>	<p>Identify issues</p> <ul style="list-style-type: none"> <li>- Create one general plan annually with updates as needed</li> <li>- Responsible: health network/partners</li> <li>- Planned during network meetings</li> </ul>
	<p>Identify target groups, e.g. school teachers and children, social service workers, law enforcement, etc</p> <ul style="list-style-type: none"> <li>- Involve GARs in public / outreach events</li> <li>- Celebrate success stories via network</li> </ul>
	<p>Development of the awareness plan with interested partners, e.g. workshop topics, number of workshops, locations, and tools</p> <ul style="list-style-type: none"> <li>- Involve ethno-cultural and religious groups as key informants</li> </ul>
	<p>Undertake evaluation of the project / plan</p>
	<p>Use media (TV, radio, newspaper) to share stories to raise public awareness</p> <ul style="list-style-type: none"> <li>- Highlight groups who have arrived recently to increase community awareness</li> <li>- Provide background info to media outlets</li> <li>- Could co-ordinate province wide with Refugee day or locally on an ongoing basis</li> <li>- Who: manager/director level</li> </ul>
<p><b>Develop and carry out a training program in cultural competency for the interdisciplinary health service team, including RAP and CSS staff and all health service delivery partners</b></p>	<p>Define cultural competency according to</p> <ul style="list-style-type: none"> <li>- Agency mandate/mission</li> <li>- Positions/parameters</li> </ul>
	<p>Explore existing resources e.g. sick kids with the collaboration of wellness centre and PHU</p>
	<p>Include cultural competency into partnership agreements</p>
	<p>Ensure all staff has cultural competency in orientation</p>
	<p>Ensure all organization dealing with GARs undergo cultural competency training</p>
<p><b>Develop and implement mechanisms for regular and formal communication and/or case management between CSS and RAP (e.g. shared office space, regular planning meetings)</b></p>	<p>Share NAT with CSS to facilitate planning at regular meetings, case conferences</p>
	<p>Have RAP and CSS share intake process and planning</p>
	<p>Formalize case handoff between RAP and CSS on leaving RAP care</p>

<b>Develop formal partnership agreements with all key health service delivery partners</b>	Identify key health service partners, e.g. CHC, FHT, PHU, universities, health promotion agencies
	Set out templates for formal partnership agreements and share across province <ul style="list-style-type: none"> <li>- Include professional development in agreement</li> </ul>
	Regular meetings as per partner (partner to decide frequency of meetings)
	Educate potential partners about RAP, CSS, IFH
	Partnerships should be reviewed/amended as needed to include new partners
	Once key service providers have been identified, CIC is to acknowledge their inclusion to any initiatives, conferences, workshops, discussions, etc.
<b>Settlement staff should be provided with training and education regarding PHIPA</b>	Identify key information for settlement staff
	Create workshop and incorporate as part of corporate orientation for new staff and provide workshops as needed if information changes and/or there are changes to PHIPA

## Endnotes

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<sup>i</sup> Pottie, Kevin, Janakiram, Praseedha, Topp, Patricia, McCarthy, Anne. Prevalence of selected preventable and treatable diseases among government-assisted refugees: Implications for primary care providers.

Canadian Family Physician. 2007. Nov; 53(11): 1928–1934

<sup>ii</sup> Lifson AR, Thai D, O'Fallon A, Mills WA, Hang K. Prevalence of tuberculosis, hepatitis B virus, and intestinal parasitic infections among refugees to Minnesota. Public Health Report. 2002. Jan-Feb;117(1):69-77.

<sup>iii</sup> Calgary Health Region. The Refugee Health and Wellbeing Project – Your Gift at Work. January 2009.

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[http://www.calgaryhealthregion.ca/programs/diversity/prog\\_services/Reach\\_Ref\\_Health.pdf](http://www.calgaryhealthregion.ca/programs/diversity/prog_services/Reach_Ref_Health.pdf)

<sup>iv</sup> Gavigan, T., Brodyaga, L. Medical Care for Immigrants and Refugees. American Family Physician. 1998. March; 57(5): 1061-8.

<sup>v</sup> Pottie, Kevin, Janakiram, Praseedha, Topp, Patricia, McCarthy, Anne. Prevalence of selected preventable and treatable diseases among government-assisted refugees: Implications for primary care providers.

Canadian Family Physician. 2007. Nov; 53(11): 1928–1934

<sup>vi</sup> Beiser, M. The health of immigrants and refugees in Canada. Canadian Journal of Public Health. 2005. Mar – Apr; 96 Supplement 2: 530 – 44.

<sup>vii</sup> Pottie, Kevin, Janakiram, Praseedha, Topp, Patricia, McCarthy, Anne. Prevalence of selected preventable and treatable diseases among government-assisted refugees: Implications for primary care providers. Canadian Family Physician. 2007. Nov; 53(11): 1928–1934.

<sup>viii</sup> Denburg, A., Rashid, M., Brophy, J., Curtis, T., Malloy, P., Audley, J., Pegg, W., Hoffman, S., Banerji, A. Initial Health Screening Results for Karen Refugees: A Retrospective Review. Public Health Agency of Canada. 2007. December; 33(13). Retrieved from:

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2231488/>

<sup>ix</sup> Ibid.

<sup>x</sup> See Current State, Background for details.

<sup>xi</sup> See Current State, Background for more information on GARs health needs and responses by CIC service providers across Ontario to address these.

<sup>xii</sup> Due to the high incidence rate of tuberculosis (TB) in the Karen refugee camps, Citizenship and Immigration Canada (CIC) implemented new operational directives/protocol to strengthen tuberculosis management for this group, including pre-departure and post-arrival management. Due to the high number of Bhutanese refugees that Canada had committed to settling (e.g., 5000 starting in 2009), health protocols were developed to provide a clear set of guidelines on immigration health examinations, screenings and treatment for conditions of public health significance that refugees have

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been submitted to prior to their resettlement to Canada. They also outline recommendations for follow-up health assessments and interventions after their arrival to Canada.

<sup>xiii</sup> Client Support Services Program: Health Related Regional Statistics Reports April 2008-March 2011.

<sup>xiv</sup> Citizenship and Immigration Canada. Information Sheet for Interim Federal Health Program Recipients.

<sup>xv</sup> ILSAT stands for "Interpreter Language and Skills Assessment Tool". It is designed to test an individual's skills in English and another language, as well as the ability to perform competently, at an introductory level, consecutive interpretation and sight translation. The Cultural Interpreter and Language Interpreting Skills Assessment Tool (CILISAT) assesses the candidate's ability in two areas: Consecutive Interpretation and Sight Translation between English and another language. Both tests have the same standing. Wherever one is accepted, so is the other.

<sup>xvi</sup> Canadian Mental Health Commission/Centre for Addiction and Mental Health. Improving Mental Health Services for Immigrants. Refugees, Ethno-Cultural and Racialized Communities. 2009. Retrieved from:

[http://www.mentalhealthcommission.ca/SiteCollectionDocuments/Key\\_Documents/en/2010/Issues\\_Options\\_FINAL\\_English%2012Nov09.pdf](http://www.mentalhealthcommission.ca/SiteCollectionDocuments/Key_Documents/en/2010/Issues_Options_FINAL_English%2012Nov09.pdf)

<sup>xvii</sup> CIC/Kappel Ramji Consulting Group. Client Support Services for Government Assisted Refugees: Evaluation of a Province Wide Pilot In Ontario, Final Report. 2009.

<sup>xviii</sup> CIC/PSTG Consulting. Language Interpretation: The Preferred Option for Addressing Language Barriers. 2011. Retrieved from [http://wiki.settlementatwork.org/w/uploads/Final\\_Report\\_Language\\_Interpretation\\_The\\_PREFERRED\\_Option\\_for\\_Addressing\\_Language\\_Barriers.pdf](http://wiki.settlementatwork.org/w/uploads/Final_Report_Language_Interpretation_The_PREFERRED_Option_for_Addressing_Language_Barriers.pdf)